WAYSIDE HOUSE OF HAMILTON
Charlton Avenue West, Hamilton, Ontario L8P (905)528-8969 Fax: (905) 528-7057

Medical Evaluation Form

Date _____ Health Card No. _____

Name _____ D.O.B. _____

Dear Doctor,

Please examine this person in order to determine whether or not he is fit to enter a two month residential rehabilitation program for drugs and/or alcohol at Wayside House.

List any significant/relevant conditions and diagnoses for which this patient has been treated.

_____

_____

Nature of treatment, if any:

_____

_____

Does this person have any communicable diseases? ☐ Yes ☐ No
If yes, please describe:

_____

Does this person have any condition pertaining to normal living, such as self care, communication or motor activities that would require special care? ☐ Yes ☐ No
If yes, please describe:

_____

Any additional information that you could provide with respect to this individual entering Wayside's DRUG/Alcohol rehabilitation program:

_____

Do you recommend assistance (Ontario Work clients) for a bus pass to enable this person to attend A.A., C.A., N.A. and aftercare meetings in order to consolidate his recovery program for a 3 month period following his residential program completion. ☐ Yes ☐ No

I,_____ authorize Dr. _____ to furnish Wayside House with medical information if it pertains to my entering the Drug/Alcohol program at Wayside. This information shall only be submitted to an authorized person and will be treated according to the Confidentiality Policy of Wayside.

Client Signature _____ Date _____

Doctor Signature _____ Date _____