PARADISE VALLEY WELLNESS CENTRE INC

3501 Paradise Valley Road, Squamish, BC Canada
PO Box 1802, Garibaldi Highlands, BC V0N 1T0
Tel 604-892-3000 Fax: 604-892-3003
www.paradisevalleywellnesscentre.com

Medical Form

Dear Physician,

Please complete this form with your patient. Your involvement is necessary, and greatly appreciated.

While Paradise Valley Wellness Centre (PVWC) is not a designated Medical Facility, there is nonetheless initial and ongoing consultation available with both a Psychiatrist and a Family Physician for those whose medical conditions require it. As a rule, any prior medical condition will - at least initially - continue to be treated according to the recommendations and prescriptions indicated by the patient's Family Physician on this form. Please be aware that patients who access our private wellness centre are required to be MEDICALLY STABLE, and have both the physical and mental capacity and resources to engage in a fairly demanding daily routine.

PLEASE NOTE: We require that patients not be in physical withdrawal – as we DO NOT offer medical detox services

We greatly appreciate your time & efforts in assisting us to assess your patient's suitability for services at our facility. The information you provide here forms a critical part of this patient's application and details are important! Please fill this form out as thoroughly and in as much detail as you are able.

Name of Patient: ______________________________

Date of Birth: ______________________________

PHN# (Care Card): ______________________________

Name of Physician: ______________________________

Telephone Number: ______________________________

Fax Number: ______________________________

Mailing Address: ______________________________

____

____

(Office Stamp)

Referral Date: ______________________________
MM DD YYYY

I hereby permit the exchange of information between Paradise Valley Wellness Centre and my personal Physician, any mental health office, Psychiatrist, Pharmanet, Health Records Departments or other medical staff who are or have been involved in my care. This consent will expire in 12 months from the date below.

____

Patient's Signature Date: MM DD YYYY

*Please note the above consent is required to process the application.

A. Medical History

How long have you been caring for this patient?

☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12 months or more

When did you last see this patient for any health concern? ______________________
Date: MM DD YYYY

(Reason?) ____

____

Past Medical History (please attach up-to-date summary sheet or printout)

____

____

____

____

☐ Heart Disease ☐ Lung Disease ☐ High Blood Pressure
☐ Asthma ☐ Diabetes ☐ Cancer
☐ Other Please provide details

____

____

☐ Endocarditis ____

☐ Overdose ____

☐ Seizures ____

☐ Surgical Hx ____

Allergies ____

B. Review of Systems

ENT ____________________________ **CNS** ____________________________
CVS ____________________________ **GU** ____________________________
RESP ____________________________ **ENDO** ____________________________
GI ____________________________ **MSK** ____________________________
SKIN ____________________________ **STD's** ____________________________
Last Menses______________________

____

____

C. Screening **(Highly recommended** as results may allow us to best serve patient; * please attach recent results*)

Liver Function Tests	**Result** ______________________	**Date** _______________
Urine Drug Screen	**Result** ______________________	**Date** _______________
HIV	**Result** ______________________	**Date** _______________
Hepatitis B	**Result** ______________________	**Date** _______________
Hepatitis C	**Result** ______________________	**Date** _______________

Date of last Chest X-ray or Mantoux test for Tuberculosis: ________________________________
(if more than one year, or unknown we require that the patient be referred for appropriate testing)

Result (or date testing requested, with cc to Paradise Valley Wellness Centre): _________________
If more convenient, a copy of the test results can be faxed to PVWC along with this information form.

D. Methadone Patients:

Patients on the methadone program are required to be stable on their current dose for **a minimum of two weeks** before starting at the centre.

How long has your patient been on the methadone program? ________________

Current dose: __________ml Length of time on current dose: _____________

Methadone Doctor _________________________ Phone number: ________________________

Length of time with this Doctor:

☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12 months or more

E. Substance Use History

Please indicate all drugs that are a problem for your patient

☐ Nicotine	☐ Alcohol	☐ Illicit Methadone
☐ Heroin	☐ Opiates	☐ Oxycontin
☐ Cocaine/Crack	☐ Cannabis	☐ Benzodiazepine
☐ Barbiturates	☐ Amphetamines	☐ Hallucinogen
☐ Prescription Drugs	☐ Over the Counter Drugs	☐ Inhalant
☐ Other: ____________________________		

Addiction History (substances, duration, “route” i.e. IV, nasal, freebase):

____

____

F. Psychiatric History

Previous Psychiatric hospitalizations? ☐ Yes ☐ No

If yes, most recent:

____

Where: ____

If less than 1 year, please provide current diagnosis and a Psychiatric Evaluation (a copy of hospital report is sufficient – and would be appreciated if available)

____

____

____

Suicide Attempts ☐ Yes ☐ No

If yes, details

____

Self-mutilation/ self-harm/ suicidal ideation? ☐ Yes ☐ No

If yes, details:

____

Depression ☐ Yes ☐ No

History or Current - please provide details

____

____

History of Violence ☐ Yes ☐ No
If Yes, please provide details:

____

____

Do you have any concerns about this patient participating in this psychosocially intensive residential service?
☐ Yes ☐ No

If Yes, why

____

G. Additional Comments

____

____

____

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H. Prescriptions

- PVWC staff will supervise patients taking their medications
- Please fax **6 week prescription supply** for your patient to Paradise Valley Wellness Centre to cover your patient's time at the centre.
- We require patients to bring originals of all triplicate prescriptions with them and upon departure from residential services, all unused medications will be returned to your patient and they will be advised to seek medical follow-up. If required, a one to two week exit prescription may be provided to your patient.

Rx: Please print clearly... (or attach current med list)

Drug Allergies: ________________________________

Medication	Dose and Frequency	Days Supply/ Quantity	Length of time on this medication

OTC Medications if different than ones listed on the Standing Orders sheet

______________________________ ________________
Physicians Signature Date

CPSBC#: ____________________

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PVWC Standing Orders

(Please cross out any which are medically contraindicated for your patient)

Patient:_______________ **Allergies:_________________________________**

Acetaminophen 500mg:

Pain/headache/fever: one to two tabs four times daily as needed. Max 8 tabs/ 24 hours. Max duration 72 hours.

Buckley's Cough Syrup Extra Strength or Nim Jiom (honey-based alcohol-free cough medicine):

Chest congestion/cough: ten mls every six to eight hours as needed. Max. 4 doses/ 24 hours.

Calcium Carbonate 750mg Life Brand (Tums):

Acid indigestion/heartburn: Chew one to two tabs every four hours as needed.

Gravol 25 – 50mg:

Nausea: every 4 to 6 hours

Ibuprophen 200mg:

Pain/headache/fever: one to two tabs four times daily as needed. Max 8 tabs/ 24 hours.

Loperamide 2mg:

Diarrhea- without persistent abdominal pain: two tabs to start; one after each loose bowel movement. Max 8 tabs/ 24 hours.

Milk of Magnesia:

Laxative: thirty to sixty mls as needed.

__________________________________ ____________________
Physicians Signature Date

SUBSTANCE USE CHART
Please fill in appropriate spaces

Substance	Amount Used Day/Week/Month	Route Used IV/etc	Age First Used	Date Last Used dd/mm/yy
Nicotine				
Alcohol				
Methadone				
Heroin				
Codeine				
Morphine				
Demerol				
Oxycotin				
Prescription Drugs				
Cocaine/Crack				
Benzodiazepines				
Marijuana/Hashish				
Amphetamines				
Barbiturates				
Over the Counter Drugs (cough syrup, Tyl-1 etc)				

Past Treatment

Facility	Name	Date In	Date Out
Residential Treatment			
Detox			
Outpatient Methadone			
Counselling			
12 Steps			

FOOD ALLERGIES

NAME: _______________________________

Foods That Cause Allergic Response:

	Life Threatening	Epipen Required	Traces Okay	Previous Severe Reaction
1. _______________________	________	________	________	________
2. _______________________	________	________	________	________
3. _______________________	________	________	________	________
4. _______________________	________	________	________	________
5. _______________________	________	________	________	________
6. _______________________	________	________	________	________
7. _______________________	________	________	________	________
8. _______________________	________	________	________	________