

Availability for Treatment:

Please identify any barriers that would delay or prevent client from attending residential treatment for a minimum of three weeks:

Acute Medical Condition(s): No Yes If yes, please specify and attach most recent medical investigation results and reports.

Chronic Medical Conditions: No Yes If yes, please specify and attach most recent medical investigations results and reports.

Medications: Printout of medications and dosages attached - if not, please list all medications below.

Current medications and herbal remedies (if space provided is inadequate, please add a sheet at the end of this form).

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Previous Medications:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Blood Work: Please note, the Concurrent Disorders Program at CCMHA requires the following blood work to be current values (within six months). Please include the following results:

- | | |
|--|---|
| <input type="checkbox"/> CBC with Differential | <input type="checkbox"/> Liver Function Tests |
| <input type="checkbox"/> TSH | <input type="checkbox"/> Therapeutic Medication Levels (as appropriate) |

Addiction Profile:

Current Substance(s) of Choice	Amount and Frequency of Use	Duration Use
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Periods of Sobriety:

Substance(s) Abstained From

Dates and Periods of Sobriety

_____	_____
_____	_____
_____	_____
_____	_____

Other Addictive Behavior(s):

Previous Treatments for Psychiatric, Addiction and/or Chronic Pain Conditions:

Program Name	Dates of Attendance	Completed	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	_____ (YY/MM/DD)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	_____ (YY/MM/DD)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	_____ (YY/MM/DD)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	_____ (YY/MM/DD)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Legal History: Does client have current legal involvement? No Yes If yes, please specify: _____

Is there any legal history involving:

Violence - No Yes If yes, please specify: _____

Drug Possession and/or Trafficking - No Yes If yes, please specify: _____

Is client currently involved in community agencies, mutual help, treatment, etc., relevant to this application?

Program Name	Dates of Attendance (YY/MM/DD)
_____	_____
_____	_____
_____	_____

Client's Treatment Goals:

Signed

Date

Please note, referrals will only be processed and considered once all requested documentation has been received. Thank you for your cooperation.

For further assistance or more information, please call 403.682.3500 or 403.682.3527