NORTHSTAR
RECOVERY

Nurse or Medical Clearance Form
(A licensed nurse or medical staff may complete this)

CLIENT PERSONAL DATA:

NAME_____ CLIENT #_____

DATE OF BIRTH_____ AGE:_____ SEX:_____

ADDRESS:_____CITY: _____

PHONE: home_____ STATE: _____ZIP: _____ cell_____

EMERGENCY CONTACT NAME: _____

AGE: _____ SEX: _____ PHONE: _____RELATIONSHIP: _____

□ I give permission to communicate with this person about my program.

MARITAL STATUS: SINGLE__; MARRIED__; WIDOWED__; DIVORCED___ : COHABITATING___:

REASON FOR ASSESSMENT: Preparation for admission to Northstar Recovery Residential Program for substance abuse recovery program.

Are you currently disabled? __Yes __No. If yes, date: _____Reason for disability:
_____

Primary Care Physician: _____ Hospital _____

Medical History and Status:
Previous hospitalizations for medical problems including surgeries(not including alcohol or drug problems):

Hospital	When	Reason
.		
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Do you have Allergies? NO___ Yes___:_____

Previous medical problems include:

Problem	Treatment	When Started	When Ended
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NAME_____ CLIENT #_____

Current medications include:

Medication	Dosage	Purpose	Doctor
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Previous Mental Health Issues or treatment:
What previous mental health treatment or counseling have you had? _____
_____

Substance abuse history:

Substance used	Age when 1st used	When Last used	Max Amount per use	Min Amount per use	Route taken: IV,Smoke	COMMENT
Nicotine						
Alcohol						
Marijuana						
Spice/K-2						
Adderall						
Opioids/Hydrcod						
Xanax/Valium						
LSD						
Mushrooms						
Oxycontin/Heroin						
Cocaine						
Amphetamines						
Ecstasy						
Other						

Family substance abuse or mental health history:
Are any family members alcoholics or addicts? (Include parents, children, grandparents on both sides of family)

Significant Family History: Who had care? What substances have been used?		
FAMILY MEMBERS	TYPE Substance abuse OR Addiction:	Psychiatric condition:
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Client Substance Abuse Treatment or Counseling:

Problem/Substance	Hospital or Outpt?	When-How long?	Facility/ Location
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MOOD SYMPTOMS: (comments about past 3 months)

Appetite change	Weight gain/loss	Dysphonia	Despair/hopelessness	Distractible
Energy change	Excessive crying	Sleep changes	Self deprecation	Suicidal/homicidal
Mania	Other			

Have you ever had a suicide attempt? NO__ Yes__ If so, when and how?

_____

ANXIETY SYMPTOMS: (Check all that you have had in the past year)

Trembling	Chest pain	Heart racing	Dizziness	Short breath
Abdomen prob/nausea	Fear of dying	Sweating	Other	

ABUSE EXPERIENCE:

TYPE	WHEN	FROM WHOM	COMMENT
Physical/domestic			
Emotional			
Sexual			

CURRENT LIVING SITUATION: (circle) in own home; with parents or family members; with other sober persons; with friends who use; in a half way house; in jail; in shelter; in weekly rental; other_____

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NAME_____ CLIENT #_____
HEIGHT: ___Feet _____ inches. WEIGHT: _____ lbs.
VITAL SIGNS: Pulse _____ Respiration _____ BP _____ Temp _____

General Physical	Normal	Abnormal	Family History	Comments
Skin				
Head,Eyes,Ears,Nose,Throat				
Heart				
Neck				
Chest/lungs				
Abdomen				
Musculoskeletal				
Neurological				
Extremities				
Nutritional				
Other				
.				
.				

Have you had a TB test in the last six months? NO__ YES ___ Results _____
PPD: Date Placed; ___Where Placed: _____Date Read_____Result_____
RPR: Date Drawn: ___Data Results _____ Comments _____
GCICHIY_____ Notes_____

Does client require further medical or mental health checkup or services?
YES____ NO_____ Client is medically and mentally appropriate for Sober Living Substance Abuse Supportive Living environment for three months or longer. Yes__ No__

Reasons: _____

Other Recommendations:

Provider Signature: _____Date: _____
Provider Name: _____Title: _____
Phone:_____
Please fax to: NORTHSTAR RECOVERY 770-719-2368

Thank you. Northstar does not admit persons without an RPR or clear TB test within the past six months. Results must be sent to the Northstar office at or before admission. Results may be sent by fax, email, mail or by hand on date of admission. Persons must not be in withdrawal from alcohol or drugs used in recent days. Persons must be at least 72 hours from last use. Persons must be able to self administer any medication prescribed and meet other admission criteria.

NORTHSTAR RECOVERY STAFF ONLY: Cleared: _____ Denied and Referred: _____
Reason: _____

Staff Name: _____ Signature: _____ Date reviewed: _____
