JOHN VOLKEN ACADEMY
WE CHANGE LIVES

Phone 1 (855) 592-3001

Pre-Admission Medical Evaluation:

Physician: Please complete the following pages and fax to John Volken Academy 1(778) 591-6768. Or email to Apply@volken.org Your patient is to be medically assessed as a potential participant of our residential recovery program. Our Program is designed to help people who acknowledge that their addiction has interfered with their effective functioning and who are physically and mentally ready to participate in an intensive program. To help us in assessing this patient's suitability to participate in our recovery program, please provide the following.

How long have you been caring for this patient? ☐ 0-6 Months ☐ 6-12 Months ☐ 12 months or more

A. **A TB test must have been performed within the last year.** The date of exam and results can either be faxed to our office or written in the space provided on the Pre-Admission Medical Evaluation.

B. **Medical Stabilization** -As we are not a medical facility, we require confirmation that the patient will be stable on any necessary medication and have a written taper plan. Any student who cannot meet Program participation standards without intense psychiatric support change or any drug replacement therapy may be dismissed, to or take any drug replacement therapy without a taper plan may be dismissed.

The John Volken Academy does not admit individuals on Vivitrol, Suboxone, or other narcotic replacement therapies without an approved taper plan that is approved by the client's physician and the Nurse Practitioner at the John Volken Academy. The John Volken Academy does not admit individuals on Methadone at this time because we cannot dispense the medicine at our location.

Name of Patient: _____ Date of Birth: _____

PHN/PHI# (Care Card)/in Canadian _____

Name of Physician: _____ City: _____

Telephone Number _____ Fax Number: _____

1. Mental Health Information

_____

_____

2. Psychiatric Hospitalizations ☐ Yes ☐ No

Places & Dates: _____

Does patient currently have a mental health worker? ☐ Yes ☐ No

If yes, please provide recent psychiatric evaluation, progress notes, and current treatment plan.

Worker/Physician: _____

Agency: _____

Phone: _____ Fax: _____

3.TB Screening -Test results must be faxed to admissions with this form.

Date of last Chest X-ray or Mantoux test for Tuberculosis: _____

(If more than **one year**, please refer for testing) Result: _____

4. Hep. C **antibody** blood work-Test results must be faxed to admissions with this form.

5.Recent HIV Test (within last 6 months) -Test results must be faxed to admissions with this form.

6. Are you currently (C) experiencing, or have you experienced in the past (P), or have you ever been tested (T) for any of the following (check all that apply):

C☐ P☐ T☐ **Asthma**
C☐ P☐ T☐ **Other Respiratory Illness or Disease**
C☐ P☐ T☐ **Heart Problems**
C☐ P☐ T☐ **High Blood Pressure**
C☐ P☐ T☐ **Chronic Nervousness/Anxiety**
C☐ P☐ T☐ **Depression or Suicidal Thoughts**
C☐ P☐ T☐ **Suicide Attempt**
C☐ P☐ T☐ **Diabetes**
C☐ P☐ T☐ **Back Problems**
C☐ P☐ T☐ **Kidney or Bladder infections/Disease**
C☐ P☐ T☐ **Menstrual Problems**
C☐ P☐ T☐ **Sexually Transmitted Disease**
C☐ P☐ T☐ **Skin Condition (ag. eczema)**
C☐ P☐ T☐ **Head Injury/Concussion**
C☐ P☐ T☐ **Seizures/Convulsions**
C☐ P☐ T☐ **Self-harming**
C☐ P☐ T☐ **Stomach and/or Intestinal Problems**
C☐ P☐ T☐ **Liver Problems**
C☐ P☐ T☐ **Aggression/violence Towards Others**
C☐ P☐ T☐ **Others** _____

---

7. Eating Disorder: Has patient had a history of Eating Disorder? ☐Yes ☐No. Is the Eating Disorder Active? ☐Yes ☐No

Anorexia _____ Bulimia _____ Binge _____ Purge _____ Restrict _____

Please provide details: _____

---

8. Current Medication(s):

Medication	Dose	Taken how many times/day?	What is medication taken for?

I certify that I have assessed the above patient and find him/her to be medically fit to participate in an intensive recovery program for substance use disorder at the John Volken Academy.

_____

Physician's Signature Day Month Year

I hereby permit the exchange of information between the John Volken Academy and my physician, any mental health office, psychiatrist, Pharma Net, Health Records Departments or other medical staff involved in my care. This consent will expire in 24 months from the date below.

_____

Patient's Signature Day Month Year

***Note: If the above consent is not signed, this application will not be processed.**

Print Submit Reset

You can also fax this document to 778-591-6768