

HALEY HOUSE - MEDICAL CERTIFICATION – pg 1 of 2

PATIENT NAME: _____ GENDER: Female DATE OF ADMISSION: _____
ADDRESS: _____ AGE: _____ DOB: _____
REFERRING AGENT: _____ PHONE: _____
ADDRESS: _____
CERTIFYING PHYSICIAN: _____ PHONE: _____

A. ALCOHOL HISTORY:

DATE OF LAST DRINK & TYPE: _____
FREQUENCY OF USE: _____

B. DRUG HISTORY:

SUBSTANCE: _____ FREQUENCY: _____ LAST USE: _____
SUBSTANCE: _____ FREQUENCY: _____ LAST USE: _____
SUBSTANCE: _____ FREQUENCY: _____ LAST USE: _____

C. DETOX MEDICATIONS:

DRUG: _____ DOSE: _____ FREQUENCY: _____ LAST USE: _____
DRUG: _____ DOSE: _____ FREQUENCY: _____ LAST USE: _____
DRUG: _____ DOSE: _____ FREQUENCY: _____ LAST USE: _____

D PSYCHIATRIC HISTORY:

DIAGNOSIS: _____ DATE: _____ TREATMENT: _____
LAST PSYCHOLOGICAL EVALUATION: _____ RESULTS: _____
IS PATIENT PSYCHOTIC?: _____ IS PATIENT SUICIDAL?: _____
HISTORY OF SUICIDE ATTEMPT? **Y/N** DATES: _____
TREATMENT(S)?: _____
IS PATIENT SELF-MUTILATING?: **Y/N** ORIENTED TO TIME, PLACE AND PERSON?: **Y/N**

E. EATING DISORDER HISTORY: Y/N – blood work may be required.

TYPE: _____ DATE: _____ TREATMENT: _____
CURRENT STATUS: _____

F. GENERAL HEALTH HISTORY:

ALLERGIES?: **Y/N**
CONVULSIONS?: **Y/N** DATE: _____ TREATMENT: _____
DT'S?: **Y/N** DATE: _____ TREATMENT: _____
HISTORY OF DIABETES?: **Y/N** TREATMENT: _____
CARDIOPULMONARY: _____
GASTROINTESTINAL: _____
GENITOURINARY: _____
OTHER HEALTH ISSUES: _____
DATE OF LAST MENSES: _____
HEIGHT _____ WEIGHT _____

G. CURRENT PHYSICAL EXAMINATION:

HEART: _____
LUNGS: _____
ABDOMEN: _____
EXTREMITIES: _____
NEUROLOGIC: _____
OTHER: _____
ANY RESTRICTIONS OR LIMITATIONS TO EXERCISE EITHER INDEPENDENTLY OR USING EXERCISE EQUIPMENT: _____

DENTAL PROBLEMS: _____

SMOKER: Y/N If Yes – is she willing to or have a desire to quit? _____

- H. **AXIS I** _____
- AXIS II** _____
- AXIS III** _____
- AXIS IV** _____
- AXIS V** _____

I. CURRENT MEDICATIONS:

DRUG: _____ DOSE: _____ FREQUENCY: _____ STARTED: _____

DRUG: _____ DOSE: _____ FREQUENCY: _____ STARTED: _____

DRUG: _____ DOSE: _____ FREQUENCY: _____ STARTED: _____

DRUG: _____ DOSE: _____ FREQUENCY: _____ STARTED: _____

DRUG: _____ DOSE: _____ FREQUENCY: _____ STARTED: _____

DRUG: _____ DOSE: _____ FREQUENCY: _____ STARTED: _____

IF PATIENT IS ACCEPTED FOR ADMISSION TO HH, PLEASE PROVIDE A 30 DAY REFILL PRESCRIPTION FOR THE PATIENT TO BRING WITH HER TO HALEY HOUSE.

J. LABORATORY WORKUP:

CBC & DIFFERENTIAL:

DATE: _____ RESULTS: _____

URINALYSIS:

DATE: _____ RESULTS: _____

RPR (Syphilis) DATE: _____ RESULTS: _____

Hb Ag (hepatitis B surface antigen) DATE: _____ RESULTS: _____

PPD DATE: _____ RESULTS: _____

AND/OR CHEST X-RAY:

DATE: _____ RESULTS: _____

RESULTS OF PPD OR CHEST X-RAY IS MANDATORY PRIOR TO ADMISSION

PLEASE INCLUDE ALL AVAILABLE MEDICAL RECORDS.

THANK YOU!

This is to certify that I have examined _____ and find her to be free of communicable diseases and not in need of nursing care. She is non-psychotic and is not bedfast and is reasonably well oriented.

DATE

PHYSICIAN'S SIGNATURE

I certify that the above information is accurate and that I enclose all medical records in my possession on this patient.

DATE

PHYSICIAN'S SIGNATURE

Please fax form to: 908-362-5450

FOR USE BY HALEY HOUSE ONLY

Date: _____ **Time:** _____ **Staff taking information:** _____

DATE OF MED. CERT. APPROVAL: _____ **ADMINISTERING**

SIGNATURE: _____