

Instructions for Completion of Medical Form

1. Make an appointment at a local doctor of your choice. Tell them you need a doctor to take several blood tests for entrance into a drug recovery program. The following are the tests/shots **required** for entrance:
 - ~**RPR Test**
 - ~**Liver Function Test Hepatitis Screening**
 - ~**Hepatitis Screening**
 - ~**Tuberculosis Test**
 - ~**Tetanus Toxoid Shot**
 - ~**Measles/Mumps/Rubella Immunization**
 - ~**HIV Test**

2. Once the doctor has completed the exam, made comments, signed the form, printed on the next page, and **attached all lab reports** for all the tests performed, you will need to contact my office and fax the results to me. Our fax number is 843-527-4140. Please let us know to be looking for them.

3. **DO NOT SEND THE FORM IF IT IS INCOMPLETE OR DOES NOT HAVE THE PROPER TESTS ATTACHED, AS IT WILL BE REJECTED IMMEDIATELY.**

4. Upon proper review, my office will assist you in reserving an admission date.



Name: _____ Birthdate: _____

1. The following lab work and copies are **MANDATORY** for admission to the program and must be included with application before time of entrance:

HIV Test: Date of result: _____
 Positive Negative

Hepatitis Screening: Date of result: _____
 Hepatitis B Positive Negative
 Hepatitis C Positive Negative

Tuberculin Test/PPD: Date read: _____
 Size: _____ If 5mm or greater a chest x-ray is required
 Chest X-ray: Positive Negative Date of result: _____

*Lab results and documents from the above items must be included with this form.
 Results included should be no older than 6 months prior to admission to the program.*

2. PE: BP _____ T _____ HR _____ RR _____ HT _____ WT _____

	NL	ABNL	If ABNL, please explain.
GEN			
HEENT			
CV			
PULM			
ABD			
M.SKEL			
DERM			
NEURO			
SEIZURES			
OTHER (specify)			

3. Please list any allergies you have to any medications, foods, or other substances: _____

4. Past medical history: _____
5. Past drug and alcohol history: _____
6. Current/routine medications:

	MEDICATION	DOSAGE
1.		
2.		
3.		
4.		

Name of Examiner (Please Print)

Address

Signature of Physician

Date of Examination

Form will be UNACCEPTABLE if examiner's title and address are ILLEGIBLE.