To Medical Professionals:

Please complete the following form to confirm medical clearance for admission to Pathways Detoxification Center.

Client Name: _____ DOB: _____

Date/s of Visit: _____

Per your observation or personal statement by the client, is the client (all required for admission):

Free from Communicable Disease (including, but not limited to):

☐ **Hep A, B, or C**

☐ **STD's**

☐ **Skin Infections**

☐ **MRSA**

Does the client have history of any of the following (may require additional information upon request):

☐ **Electrolyte abnormalities**

☐ **Active infection**

☐ **Multiple medical comorbidities**

☐ **Associated use of benzodiazepines**

Any of the following disqualifies the client from services at our Sub-Acute Detoxification Center:

☐ **Prior history of seizures**

☐ **Prior severe withdrawal**

☐ **Marked autonomic hyperactivity**

Ambulatory without assistance? Y or N (please circle)

Any other medical concerns/diagnosis that we should be aware of: Y or N (please circle) **and explain:**

_____

_____

If applicable, TB results:

PPD: Date Placed: _____ Where Placed: _____

Date Read: _____ Result: _____

Please contact Pathways Detoxification Center if you have any question regarding this form or allowable medications. Results can be faxed to 920-894-1373. Thank you!

_____ _____

Medical Professional Signature Date

_____

Name of Clinic/Hospital