

To Medical Professionals:

Please complete the following form to confirm medical clearance for admission to Pathways To A Better Life, LLC, a residential alcohol and drug treatment facility. Please call 920-894-1374 with any questions.

Client Name: _____ DOB: _____

Date/s of Visit: _____

***Per your Observation or a Statement from the client, is the client** (all required for admission):

Please INITIAL to indicate patient is Free from Communicable Diseases, including but not limited to:

___ Hep A, B, or C ___ STD's ___ Skin Infections ___ MRSA

Free of all withdrawal symptoms requiring medical attention: Yes or No (please circle) and explain:

Ambulatory without assistance? Yes or No (please circle) and explain:

Any other medical concerns/ diagnosis that we should be aware of? Yes or No (please circle) and explain:

*TB test is mandatory for admittance. (Pathways staff will read and document results.)

PPD

Date Placed: _____ Where Placed: _____ Signature: _____

Date Read: _____ Result: _____ Signature: _____

*The following over-the-counter medications are approved for this patient to be given per package instructions unless otherwise indicated. (Please initial to indicate approval.)

___ Acetaminophen 500mg, 1-2 tabs q 8hrs PRN discomfort	___ Imodium
___ Ibuprofen 600mg q 6hrs PRN discomfort	___ Anti-fungal Cream
___ Benadryl 25mg-50mg q 8hrs PRN allergies	___ Cough Drops
___ Melatonin 3mg-10mg tabs PRN sleep	___ Triple Antibiotic Cream
___ OTC Vitamins / Supplements	___ Athlete's Foot Powder
___ Acid Reducing Medications (PPIs)	___ Stool Softener
	___ Cold/Flu Medication
	___ Antacid / Tums

Please contact Pathways To A Better Life, LLC if you have any questions regarding this form or allowing medications. Results can be faxed to 920-894-1373. Thank you!

Medical Professional Signature (MD / NP Only)

Date

Name of Clinic / Hospital

