To Medical Professionals:

Please complete the following form to confirm medical clearance for admission to Pathways to a Better Life, LLC. A Residential AODA (Alcohol and Drug Abuse) Treatment Program.

Client Name: _____ DOB: _____

Date/s of Visit: _____

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

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? 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 to a Better Life, LLC 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