MEDICAL CLEARANCE FOR SUBSTANCE ABUSE TREATMENT

Client Name:_____

Client Date of Birth:_____

Date and Location of Medical Clearance:_____

_____ is medically clear to go to a 90-day residential co-occurring facility.

- Medical problems are stable.
- He/she will not need to leave program to attend multiple medical clinic visits during the 90 days.
- He/she is able to participate in 40 hours of group per week.

Primary Diagnosis:_____

Secondary Diagnosis (if applicable):_____

His/her daily medications and dosages are:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Instructions for follow-up (If applicable):_____

_____

_____

_____

Physician Name:_____

Physician Signature:_____

Date:_____