Georgia Strait
WOMENS CLINIC

Client Readmission Form

This is an interactive document. Simply place your cursor over the item you wish to fill in and begin typing.

Please complete, print this document and fax to 1-888-875-0511. A staff member will contact you within 24 hours.

Birthdate: MM/DD/YYYY

Allergies:

Admission: MM/DD/YYYY

Date: MM/DD/YYYY

Client (Patient) Information:

Name:

Address:

Age:

Date of Birth: MM/DD/YYYY

Email address:

Telephone Numbers

Home:

Cell:

Other (specify):

Provincial Health Care No. :

Extended Health Care No. :

Extended Health Carrier:

Group Plan No. (Back of Card):

Requested Admission Date:

◯ Will you be needing travel assistance?

◯ Will you be needing withdrawal management (detox)?

Funding Guarantor (if different from client):

Name:

Address (Street/PO Box):

City/Town:

Prov/State:

Postal/Zip:

Telephone Numbers

Home:

Work:

Relationship to client?

◯ self-pay ◯ EAP ◯ employer ◯ family member ◯ other

Payment:

How will you be paying?

◯ cheque ◯ money order ◯ wire transfer ◯ credit card

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Please describe your current problematic substance use

Name of problematic substance :

Pattern of use (daily, weekend, binge):

Amount used per occasion:

Length of use:

Date of last use:

Name of problematic substance:

Pattern of use (daily, weekend, binge):

Amount used per occasion:

Length of use:

Date of last use:

Name of problematic substance :

Pattern of use (daily, weekend, binge):

Amount used per occasion:

Length of use:

Date of last use:

Problematic behaviour (e.g., gambling, online pornography, etc.)

Pattern of use (daily, weekend, binge):

Time or money spent per occasion:

Length of last use:

Date of last use:

Are you currently on a replacement therapy such as Suboxone or Methadone? ◯ No ◯ Yes

If yes, name of replacement therapy:

Dosage:

Length of time on this dosage:

Are you currently on any prescribed medications? Include any prescription you have chosen to discontinue. ◯ **No** ◯ **Yes**

If yes, name of prescribed drug:

Dosage:

Length of time on this medication:

Name of prescribed drug:

Dosage:

Length of time on this medication:

Name of prescribed drug:

Dosage:

Length of time on this medication:

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Have you recently been hospitalized? ◯ No ◯ Yes

If yes, please describe and provide dates:

Are you currently taking any nutritional supplements or herbal medicines? ◯ No ◯ Yes

If yes, name of nutritional supplement or herbal medicine

Dosage:

Length of time on this nutritional supplement or herbal medicine:

Name of nutritional supplement or herbal medicine:

Dosage:

Length of time on this nutritional supplement or herbal medicine:

Name of nutritional supplement or herbal medicine

Dosage:

Length of time on this nutritional supplement or herbal medicine:

Please note that any nutritional supplement or herbal medicine brought to treatment is subject to confiscation and disposal. Any exceptions must be pre-approved by medical staff.

Precipitating Event and Motivation:

Has a specific event(s) prompted this return?
◯ No ◯ Yes

If yes, please describe:

What else is motivating your return to treatment?

Lack of social support/feelings of loneliness and isolation ◯ No ◯ Yes

Relationship problems with partner or family members ◯ No ◯ Yes

Money problems/dissatisfaction with work
◯ No ◯ Yes

Physical health problems ◯ No ◯ Yes

Mental health problems ◯ No ◯ Yes

Problems with living arrangement or housing
◯ No ◯ Yes

If yes to any, please describe:

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What do you think you need to work on the most during your return to GSWC? Describe:

On a scale of 1 to 10 (1 being very low and 10 being very high) rate the extent to which you are currently experiencing the following emotions in anticipation of your return to GSWC:

Hope
Fear
Anxiety
Relief
Shame
Hopelessness
Dread
Frustration
Optimism
Anger
Resentment

Comment:

SUBMIT