The Maples Adolescent Residential Program

Name:	**DOB:**
Allergies: ☐ NONE ☐ YES: _____	**Reported Reactions:** _____

Immunizations complete? Please attach proof of completion.	☐ Yes ☐ No	If "No" list which immunization(s) missing:
	Reason Missing:	

Medical History:

Primary Care Provider:

List any Current Diagnosis:

Yes	No	
•	•	Asthma: Asthma Action Plan • Yes • No (please attach)
•	•	Diabetes: Type I___ Type II___
•	•	Seizure Disorder (date of last known seizure):
•	•	Cardiac Issues
•	•	TBI or Head Trauma (date):
•	•	History of MRSA
•	•	Other (please specify):

Surgical History (please include date of procedure):

Family History of Psychiatric Disorders and Substance Use (please list relationship and diagnosis):

List your current prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	Continue while attending residential program?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

PHYSICAL EXAM

Examination Date: _____

HR: _____ **SpO2:** _____ **HT:** _____ **BMI:** _____

BP: _____ **RR:** _____ **WT:** _____ **TEMP:** _____

Check = Normal findings; if abnormal, please provide explanation **Date Exam Completed: _____**

•	General:	•	Neurological:
•	HEENT:	•	Extremities:
•	Skin:	•	Genitals:
•	Heart:	•	Dental/Oral:
•	Lungs:	•	Other:
•	Abdomen:	•	**The entire examination was WITHIN NORMAL LIMITS**

Labs Completed – PLEASE ATTACH RESULTS

•	CMP	•	HIV
•	CBC	•	RPR
•	TSH	•	Chlamydia/Gonorrhea

The Maples Adolescent Residential Program

	Urine Analysis		Lithium level (if applicable)
•	Urine Drug Screen	•	Depakote level (if applicable)
•	Urine Pregnancy	•	Tuberculosis
•	EKG	•	COVID

Specialized Diet

Is there a need for a specialized diet due to medical issues? ☐ Yes ☐ No

If yes, please describe:

Recreational Drugs and Alcohol Use

		Substance	*Amount*	*Route*	*Frequency*	*Last use*
☐ Yes	☐ No	Alcohol				
☐ Yes	☐ No	BZO				
☐ Yes	☐ No	THC/Synthetic THC				
☐ Yes	☐ No	Opiates				
☐ Yes	☐ No	Kratom				
☐ Yes	☐ No	Cocaine				
☐ Yes	☐ No	Amphetamines/ Prescription Stimulants				
☐ Yes	☐ No	Methamphetamine				
☐ Yes	☐ No	MDMA(Molly/Ecstasy)				
☐ Yes	☐ No	Psychedelics (LSD/Mushrooms)				
☐ Yes	☐ No	Other: _____				
History of blackouts?					☐ Yes	☐ No

Comments:

• Yes	No	**I determine that this patient IS MEDICALLY CLEARED to attend and fully participate in a psychiatric residential treatment program WITHOUT any physical restrictions.**
• Yes	• No	**I determine that this IS MEDICALLY CLEARED to attend and fully participate in a psychiatric residential treatment program WITH the following LIMITATIONS (list all limitations/restrictions):** 1. _____ 2. _____ 3. _____
• Yes	• No	**I determine that this patient is NOT MEDICALLY CLEARED to attend and fully participate in a psychiatric residential treatment program at this time based on the following:** 1. _____ 2. _____ 3. _____

Provider Name: _____ **Provider Signature:** _____ **Date:** _____

• **Medical Doctor** • **Nurse Practitioner** • **Other:** _____

Name of facility: _____	**Telephone:** _____
Facility Address: _____	**Fax:** _____

_____

_____

The Maples Adolescent Residential Program