WINDS Recovery House

Women Integrating New Directions in Sobriety

P.O. Box 212
Grafton,WI 53024
262-444-1201
www.windsrecovery.org

MEDICAL CLEARANCE FORM

TODAY'S DATE: ____________________

To The Medical Professional,

Please complete the following medical clearance form at the request of the applicant. This form confirms she meets reasonable health standards to reside at WINDS Recovery House.

CLIENT NAME: ____ DOB: ______________

TYPE OF VISIT: EMERGENCY ROOM / URGENT CARE / DOCTOR'S OFFICE / RESIDENTIAL CARE
OTHER: ____

To the best of your knowledge and examination, please document whether the client is:

Free of all controlled substances, including Scheduled I-IV substances, for the past 30-days? Y / N (If no, please explain.)

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____

Free of all withdrawal symptoms requiring medical assistance? Y / N (If no, please explain.) ____________________

____

Able to perform personal cares independently? Y / N (If no, please explain.) ____________________

____

Ambulatory without need of personal assistance? Y / N (If no, please explain.) ____________________

____

Please record any other medical concerns/diagnosis we should be aware of. ____________________

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If applicable, TB test results: PPD: Date Placed: ______________ Where Placed: ______________
Date Read: ______________ Result: ______________

For any questions or concerns regarding the client residing at WINDS Recovery House, please contact the House Manager at the phone number listed on this form.

____

Medical Professional's Printed Name Date

____

Medical Professional's Signature Date

____

Address Phone

6/9/17