De Novo Treatment Centre

Medical Clearance Certificate

Please complete this form and return to De Novo Treatment Centre by fax, or email: 705-788-2607 admissions@denovo.ca

Client Information:

Client Name _____ DOB: _____

Address: _____ Phone: _____

Medication that should be continued during treatment (please do not include temporary/ withdrawal medications):

Medication:	Prescribed for (anxiety, sleep etc.):	Dosage:	Frequency:

Is this individual:

- Able to use nicotine patches, gum, etc., for smoking cessation? yes ☐ no ☐
- Exhibiting symptoms of cold/flu or travelled outside of Canada recently? yes ☐ no ☐

** **Methadone and Suboxone** scripts must be provided to our local pharmacy. (Suboxone, 35-day supply in blister packs and Methadone, seven-day supply delivered each week to the care of De Novo). PRN mood altering medication is reviewed on an individual basis. **

ALL MEDICATION MUST BE IN BLISTER PACK & 35 DAY SUPPLY

Physician/ Nurse Practitioner Contact Information:

Name:_____ Phone:_____

Address: _____ Fax: _____

The above named, person has been assessed by me, on this date and is medically and psychologically capable of full participation in a 35-day residential treatment program for substance use disorder.

Physician/ Practitioner Signature:

_____

Date: _____

Stamp

Accredited by Canadian Centre for Accreditation
Agréé par Centre canadien de l'agrément

87 Forbes Hill Drive. Huntsville ON. P1H 1R1
Phone: (705) 787-0247 Fax: (705) 788-2607 Toll Free: 1-800-9-DE NOVO/1-800-933-6686
Revised: May 2022