rhd RESOURCES FOR HUMAN DEVELOPMENT

New Perspectives

Together, we're better

Medical Clearance Statement

Consumer Name: ____ SSN: _____________ DOB: ____________

I, ____________________, certify that on ____________________, I evaluated ______________________,
Printed Name of Medical Professional Date Name of Consumer

and affirm that no medical conditions are present that would preclude living in a group-home setting, at New Perspectives Crisis Residence. I am aware that nursing services are not available 24 hours daily, and that the above named consumer must be able to independently take their medications, ambulate and care for their physical health needs, etc.

Program Description states that New Perspectives cannot accept persons who:

1. Are in need of drug or alcohol detoxification
2. Are currently inebriated
3. Have an untreated seizure disorder
4. Are in need of physical restraint
5. Have a significant history of assaultive behaviors
6. Are in need of emergency care
7. Has a current diagnosis of a communicable disease
8. Other – as determined by team

Is the above named consumer in need of on-going medical follow-up? YES NO (Circle One)

If **YES**, for which medical conditions? ____

____

____ ____________________
Printed Name of Medical Professional Date

____
Signature Name of Medical Professional

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