WOLFE Family Wellness - Medical Assessment Form

To be completed by a Doctor, Nurse Practitioner, or Registered Nurse for each participating family member, when required by WOLFE or the referral partner.
The individual named below is being considered for participation in WOLFE Family Wellness programming. Please identify any medical, medication, mobility, mental health, pregnancy/postpartum, withdrawal, infectious illness, or follow-up needs that may affect participation, safety, or daily programming.

Date of assessment	
Participant first name	
Participant last name	
Date of birth	
Age	
Gender / pronouns	
Alberta Health Care number	
Treaty/status number, if applicable	

Please indicate any medical illnesses, diagnoses, accessibility needs, or current health concerns:

Are there any current or recent medical concerns requiring follow-up while in the program? If yes, please explain:

Continues

Please list all current medications, including medication name, dosage, indication/reason, prescribing provider, and duration:

Medication Name	Dosage	Indication/Reason	Prescribing Provider	Duration

Allergies, dietary restrictions, mobility limitations, or safety concerns:

Name of Doctor / Nurse Practitioner / Registered Nurse		Office Stamp
Clinic / office name		
Address		
City		
Province		
Postal code		
Telephone		
Provider signature		
Date		

PLEASE ADD ANY ADDITIONAL RECORDS AS NEEDED FOR TREATMENT