

# LIFE CHALLENGE of WESTERN NORTH CAROLINA

P. O. Box 2553, Cullowhee, NC 28723

Phone: 1-866-697-0055

*Chosen, Changed, Complete for Life*

## Physician Recommendation Form

I am applying for admittance into the Life Challenge of Western North Carolina residential discipleship program. In order to complete my application, I need a physician to complete the following reference form regarding my current status and run the medical tests in Section III. I give permission and authorize you to release the information requested below to Life Challenge of Western North Carolina. I also give you permission to release any medical notes to them to help them make the best decision for my recovery. After completion, this form is to be mailed or faxed directly to the center – do not return the form to me.

\_\_\_\_\_  
*Applicant Signature*

\_\_\_\_\_  
*Date*

### I. General Information

Applicant Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Respiratory \_\_\_\_\_  
Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

### II. Laboratory

Please test for the following communicable & sexually transmitted diseases.

Copies of the actual lab reports **must be** faxed to Life Challenge of Western North Carolina.

1. Venereal Disease RL or RPR
2. Hepatitis A
3. Hepatitis B
4. Hepatitis C
5. HIV
6. Pregnancy
7. Tuberculosis

### III. Medical History

Check the following areas with the applicant. Respond in detail where abnormalities exist.

- Eyes, ears, nose, throat \_\_\_\_\_
- Dental and Oral \_\_\_\_\_
- Respiratory \_\_\_\_\_
- Cardiovascular \_\_\_\_\_
- Endocrine \_\_\_\_\_
- Gastro-intestinal \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Genito-Urinary \_\_\_\_\_
- Musculoskeletal \_\_\_\_\_
- Neurologic \_\_\_\_\_

• Dermatologic \_\_\_\_\_

#### IV. Life Controlling Problems

Note the current condition of the applicant in regards to the following areas. Note in detail your professional assessment and/or recommendations.

• Psychiatric \_\_\_\_\_

\_\_\_\_\_

• Alcoholism \_\_\_\_\_

\_\_\_\_\_

• Drug abuse/Addiction \_\_\_\_\_

\_\_\_\_\_

#### V. Family History

Has the (1) client or (2) family member suffered from any of the following conditions. Please respond with Yes or No. Also, if yes on a family member; please list the family member.

Nervous Breakdowns (1) \_\_\_\_\_ (2) \_\_\_\_\_ Who? \_\_\_\_\_

Suicide or Attempts (1) \_\_\_\_\_ (2) \_\_\_\_\_ Who? \_\_\_\_\_

Migraine Headaches (1) \_\_\_\_\_ (2) \_\_\_\_\_ Who? \_\_\_\_\_

Sleeping Medications (1) \_\_\_\_\_ (2) \_\_\_\_\_ Who? \_\_\_\_\_

#### VI. Your Professional Opinion

What is your Diagnosis of the current condition of the Applicant? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

Life Challenge of Western North Carolina is not a medical care facility and is unable to provide any onsite medical supervision. Therefore all students entering the program must be in good health. If an applicant's health requires medical supervision, Life Challenge of Western North Carolina is not the appropriate program. We do not have the facilities to provide health care for students.

**In my opinion, this person is stable enough physically, mentally, and emotionally to participate in a 12 month residential program involving teaching, learning, work responsibilities, and strict discipline to help produce a self-disciplined life.**

Doctor's Signature: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

*If you have any questions: Contact the Director of Student Services at (704) 546-2531.*