STATEMENT TO BE FORWARDED TO THE MEDICAL SUPERINTENDENT, WHEN APPLICATION IS MADE FOR THE RECEPTION OF A PATIENT.

1. Name of patient (in full),
2. Where born,
3. Son (or daughter) of,
4. Residence County of,
5. Age Last Birthday,
6. State as to marriage,
7. Number and age of Children.
8. Occupation, (or that of Father or Husband).
9. Natural Disposition,
10. Habits in Health—as to Temperance, etc.
11. Education.
12. Religion.
13. Age at first attack,
14. Insanity, how first manifested.
15. Number and duration of attacks.
16. Where under treatment, and when.
17. What relatives similarly affected.
18. Supposed cause, Remote,
19. " " Recent,
20. Duration of present attack.
21. State as to sleep,
22. Appetite for food,
23. State of bodily health.
24. Whether subject to Epilepsy.
25. Any faltering of Speech, or loss of power.
26. Present habits and propensities.
27. What Delusions.
28. Whether Suicidal (attempted or threatened), and how.
29. If dangerous to others, how.
30. Pecuniary Circumstances, (or to whom chargeable.)
31. Post-office address of nearest friend, and degree of relationship.
32. Other Particulars.

I Certify that to the best of my knowledge the above particulars are correctly stated; and I hereby request you to receive the above named ———— whom I last saw at ———— on the —— day of ——, (being within one month from this date,) as a person of unsound mind, as a patient into the Nova Scotia Hospital for the Insane.

Name.

Address.

Date,

Degree of relationship (if any) or other circumstances connected with the patient.

N. B.—If any of the particulars in this statement be not known, the fact to be stated. No patient to be sent to Hospital until a reply shall have been received to this statement.