main street project
building stability

DETOXIFICATION AND STABILIZATION PROGRAM

APPLICATION FORM

Applying to attend:

☐ **Men's Facility** ***(male identified)*****:** 75 Martha Street, Winnipeg, MB R3B 1A4
General Inquiries: 204-982-8251 Admissions: 204-982-8227 Fax Number: 204-982-8266

☐ **Women's Facility: (female identified):** 146 Magnus Ave**,** Wpg, MB R2W 2B4
General Inquiries: 204-982-8222 Admissions: 204-982-8223 Fax Number: 204-982-8220

Client Information: Please print clearly. **Date of Application:** _____

FIRST NAME ***(legal name)***	***MIDDLE NAME***	***LAST NAME***	
Other names known by:	Gender: ☐ M ☐ F ☐ T	Date of Birth	AGE
MB Medical: *9 digit*	*6 digit*	Treaty? ☐ Yes ☐ No Treaty # Band:	

Employment Status: ☐ Unemployed ☐ Employed: _____ ☐ Disability

Source of Funding (specifically for medications): ☐ EIA ☐ Insurance ☐ Pension ☐ Trustee ☐ Self Pay ☐ Other
Please provide detailed info (i.e. EIA worker name/phone/office)

Emergency Contact Person: ***Name and Phone number***
Can messages be left with this person? ☐ *Yes* ☐ *No*

MSP Program Involvement: ☐ IPDA ☐ Shelter ☐ Mainstay ☐ The Bell ☐ Previous Detox stay date: _____

Do you have any, CFS visits or other appointments scheduled while you will be in detox? ☐Yes ☐ No

***Note: leaving the program is not often permitted, therefore you may be asked to re-schedule your appointments while in detox**

Do you plan to attend a treatment program after detox? ☐ Yes ☐ No If yes, which one
☐ Anchorage ☐ BHF ☐ AFM ☐ Tamarack ☐ UGM ☐ Pritchard House ☐ Other _____

Housing and Contact Information: PHONE NUMBER:

Address *(if applicable):* **Email address:**

What is your current living situation:

☐ Safe housing	☐ Living in transitional housing	☐ Living on the street
☐ Living with family	☐ Living with friends	☐ Common shelter user
☐ At risk of homelessness	☐ Living out of City	☐ Living out of Province
☐ Was in hospital	☐ Currently in a Treatment Program	☐ Crisis Unit
☐ Jail (just left)	☐ Other: _____	

Referral Source: *(check all that apply)*

☐ **HSC AFTER HOURS:** Time of referral: _____ Time of Clients Arrival: _____

☐	Self-referral	☐	HSC or other Hospital (not afterhours):
☐	Treatment Program *(which one)*	☐	Internal MSP program (IPDA/Shelter/Bell/Mainstay)
☐	Support Worker *(who)*	☐	CFS Mandate/Legal Mandate
☐	EIA	☐	Crisis Response Centre (CRC)
☐	Community Agency *(which one)*	☐	Other

SUBSTANCES CURRENTLY USED

Please use this section to let us know what types of substances you are using (i.e alcohol/drugs/solvents)

Which substance(s) do you need detox for?

First Substance of Choice		**How often do you use this?**
Second Substance of Choice		**How often do you use this?**
Third Substance of Choice		**How often do you use this?**

Are you an injection drug user? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No

OPIOID ASSESSMENT INFORMATION

Do you use Opioids? ☐Yes ☐ No

Do you feel sick when you stop using opioids? ☐Yes ☐ No

Are you on Methadone or Suboxone? ☐Yes ☐ No If yes, who provides your prescription?
If yes, A Client Agreement must be filled out/transfer to Brother's pharmacy)

Are you interested in Opioid Replacement Therapy?

*if interested in replacement therapy or already on Methadone/Suboxone please complete the opioid referral form with an MSP staff.

MEDICAL INFORMATION

Do you have a Doctor? ☐Yes ☐ No **Doctor Name:**	**Location/phone:**	Last Visit:

Do you have any medical appointments scheduled while you will be in detox? ☐Yes ☐ No

Are you pregnant? ☐Yes ☐ No If yes, how many weeks? Do you think you might be pregnant? ☐Yes ☐ No

Do you have an mental health concerns/issues:

Have you had any suicidal thoughts in the past 7 days ☐Yes ☐No If yes, last time:

Do you use suicidal ideation to help you cope? ☐Yes ☐No If yes, how often?

Have you had any suicide attempts ☐Yes ☐No If yes, how often/last time:	☐ Do you have any history with self-harm If yes, how often/last time:

LEGAL INFORMATION

Do you have a No Contact Order (NCO), Peace Bond, or Restraining Order against anyone or against you? ☐ Yes ☐ No
If so, provide details?

Do you have any outstanding legal issues/court dates that will happen while you are in detox? ☐ Yes ☐ No

Are there any individuals that you may have an issue with that could be in detox? ☐Yes ☐ No

MSP OFFICE USE ONLY BELOW THIS LINE

MSP staff person completing/reviewing application with client: _____

☐ HIFIS database has been checked ☐ New Client or ☐ Existing Client / File Number: _____

If this client has stayed in any program at MSP please indicate the last program stay: _____ Date: _____

Case Worker Assigned:

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MEDICAL CLEARANCE FORM

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The Detoxification and Stabilization Program at Main Street Project accepts all individuals who are in need of withdrawal support from drugs or alcohol. **The average stay is 10 days but this may be extended, depending on need.** A MEDICAL CLEARANCE IS REQUIRED IN ORDER TO BE ADMITTED TO THE MSP DETOX PROGRAM.

Note to Practitioner: Medications need to be in Pac med packaging from Broadway Pharmacy. Please fax the clients Rx directly to the pharmacy. Broadway Pharmacy Phone: 204-783-1887 **FAX: 204-786-6990. ALL MEDICATION THAT THIS INDIVIDUAL IS TAKING MUST BE LISTED ON THIS FORM.**

To be Completed by a Physician, Nurse Practitioner (NP), or Physician Assistant (PA) **PLEASE PRINT**

Date: _____ ***This form will be valid for 72 hours unless otherwise stated:*** _____
Expiry date

Client Name: _____ **DOB:** _____

PHIN #: _____ **MHSC #:** _____ **Gender:** ☐ **M** ☐ **F** ☐ **Transgender**

Is this client a regular patient of yours? ☐ Yes ☐ No **Last seen by you:**	Is this patient pregnant: ☐ Yes ☐ No # of weeks _____

Does this patient have history of any of the following:

	Yes	No		Yes	No		Yes	No
Seizures			**Diabetes**			**Asthma**		
Allergies			***Epi Pen needed**			**Temp. Physical Ailment**		
HIV			**Hep C**			****Mental Health Diagnosis**		

Has a lice/scabies check been completed? ☐ **Yes** ☐ **No** **Does this client have lice/scabies?** ☐ **Yes** ☐ No

*If this client needs an Epi pen or equivalent it must be prescribed

Do any of the above that are checked off Yes interfere with attending detox? ☐ Yes ☐ No

Please explain:

MENTAL HEALTH STATUS: Has this patient been diagnosed with any of the following:

☐ **Unknown** (if you are not this patients regular doctor and do not know if they have a diagnosis please check this box)

☐ Depression	☐ Anxiety	☐ Personality Disorder
☐ Bipolar	☐ Social Anxiety	☐ Mood Disorder
☐ PTSD	☐ OCD	☐ Phobia
☐ Schizophrenia	☐ Psychosis	☐ Dementia

☐ Other (please be specific)

Has Medication been prescribed for any diagnosis indicated above ☐ **Yes** ☐ No *please make sure all meds are listed on reverse*

Please indicate any issues that need to be addressed while at detox regarding this patient's mental health stability:

In the <u>past 30 days</u> what drugs/alcohol has this patient been using?

Substance Used	How Much	How Often

PLEASE LIST <u>ALL MEDICATIONS</u> THAT THIS CLIENT WILL BE TAKING WHILE IN DETOX, this includes all **pre-existing medications that this individual has been taking if they need to continue taking it while at detox.** Opioid Use will require a safe admission assessment which can be obtained through the MSP detox program.

<u>A new 10 day prescription</u> for all medications, including OTC medications, must be in the original **Pacmed packaging** from Broadway Pharmacy prior to an individual being admitted to MSP detox. **Broadway Pharmacy Ph# 204-783-1887 fax: 204-786-6990 . PLEASE NOTE WE DO NOT HAVE OTC MEDICATIONS ON HAND, IF YOUR PATIENT NEEDS OTC MEDICATION YOU MUST PROVIDE A PRESCRIPTION FOR THEM.**

Medication Name	Directions		Medication Name	Directions

Funding Source: ☐ EIA _____ ☐ Treaty: #_____ ☐ Self Pay ☐ Other (i.e. insurance)

IS METHADONE/BUPRENORPHINE/SUBOXONE CURRENTLY PRESCRIBED? ☐ Yes ☐ No
**** If yes please note that a client agreement form will need to be completed with MSP staff prior to being accepted into the detox program and any Rx required will be transferred to Brother's Pharmacy unless the current pharmacy can dose on site at the MSP detox program. The exception to this is any individual is in the MOST attending at River Point Centre.

PHYSICIAN/NP/PA NAME: _____ Phone:_____

Address: _____ After Hours contact:_____

<u>Do you approve this patient to attend our Detoxification Program?</u> □ **Yes** □ **No** ***<u>*we do not have doctors or NP's on staff*</u>*

Any additional information that we need to know: _____

_____

Physician/NP/PA Signature: _____

****MEDICATIONS PRESCRIBED ARE FOR USE WHILE IN DETOX ONLY. THESE <u>MEDICATIONS WILL NOT BE GIVEN BACK</u> TO THE CLIENT ON DISCHARGE AND <u>WILL NOT BE AVAILABLE FOR PICK UP</u> AT THE PHARMACY ****