main street project
building stability

DETOXIFICATION AND STABILIZATION CENTRE

MEDICAL CLEARANCE FORM

Applying to attend:

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

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

The Detoxification and Stabilization Centre at Main Street Project Inc. accepts all individuals who are in need of withdrawal support from drugs or alcohol. Depending on the needs of each client, **the stay can be 5 - 15 days or more.** People considering admission to the MSP Detox Centre must have a medical assessment and clearance.

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.**

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

Date: _____ ***This clearance will be valid for 72 hours from this date unless otherwise stated:*** _____

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 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 *Example: crack*	How Much *2 rocks*	How Often *daily*

PLEASE LIST ALL MEDICATIONS THAT THIS CLIENT WILL BE TAKING <u>WHILE IN DETOX.</u>

<u>A new 14 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 . <u>PLEASE NOTE, WE DO NOT HAVE ORT MEDICATIONS ON HAND. PRESCRIPTIONS FOR ORT ARE REQUIRED WITH DAILY ADMINISTRATION BY THE PHARMACY OR TRANSFER TO BROTHERS PHARMACY FOR ADMINISTRATION.</u>**

Medication Name	Directions		Medication Name	Directions

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

IS METHADONE/BUPRENOPHINE/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 need to be transferred to BROTHERS PHARMACY for the duration of the client's stay in detox unless the current pharmacy is able to dose on site at the MSP detox program. The exception to this is any female identified individual in the MOST program attending Riverpoint Center.**

PHYSICIAN/NP/PA NAME: _____ Phone: _____ Fax: _____

Address: _____ After Hours contact: _____

<u>Do you approve this patient to attend our Detoxification Centre?</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 PRECRIBED ARE FOR THE USE WHILE IN DETOX ONLY. THESE MEDICATIONS WILL <u>*NOT BE RETURNED*</u> TO THE CLIENT UPON DISCHARGE AND WILL <u>*NOT BE AVAILABLE FOR PICK UP*</u> AT THE PHARMACY**