Withdrawal Management Medical Clearance Form

☐ Male Identified and Non-Binary Facility: 71 Martha Street, Winnipeg, MB R3B 1A4
General Inquiries/Admissions: **204-982-8251** Fax: 204-982-8266

☐ Female Identified and Non-Binary Facility: River Point Centre, 146 Magnus Ave, Winnipeg, MB R2W 2B4
General Inquiries/Admissions: **204-982-8222** Fax: 204-982-8220

The Detoxification and Stabilization programs at Main Street Project Inc. accept all individuals who are in need of withdrawal support from drugs or alcohol. Depending on the needs of each Participant, Participants can stay up to 14 days. People considering admission to the MSP Withdrawal Management must complete a medical assessment and this clearance form before admission.

Note to Practitioner: Medications need to be in Pac Med packaging from **Northway Broadway Pharmacy.** Please fax the Participant's prescription directly to the noted pharmacy. Northway 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: __________________ *Medical clearances are only valid for 72 hours unless otherwise indicated by the Physician

To extend beyond the expiry date, please indicate the new date of expiry here: _____________________

Participant Name: ____ **DOB:** ______________________

Best Method of Contact for Participant: ____

PHIN #: _____________________________ MHSC #: ________________ Treaty #:_______________________

Gender: ☐ Cismale ☐ Cisfemale ☐ Transmale ☐ Transfemale ☐ Non-Binary ☐ 2- Spirit ☐ Intersex ☐ Agender
☐ Other: _______

Is this Participant a regular patient of yours? Last seen by you:	**Funding Source:** ☐ Treaty ☐ EIA ☐ Self Pay ☐ Insurance ☐ Other

Does the Participant have a history of or is currently experiencing of any of the following Medical Conditions?

	Yes	No		Yes	No		Yes	No
Seizures			Pregnancy ____# weeks			Diabetes		
Asthma			Stroke/Heart Attack			HIV		
Cancer			Temp Physical Ailment			Hep C		

Notes On Anything Notated as Yes Above:

Allergies: ☐ Yes ☐ No Epi Pen Required ☐ Yes ☐ No Epi Pen Prescribed ☐ Yes ☐ No

List:

Has Lice/Scabies check been completed? ☐ **Yes** ☐ **No** Does Participant have lice/scabies ☐ **Yes** ☐ **No**
(If yes, please prescribe treatment in medication section)

Was STBBI Testing completed: ☐ Yes ☐ No If no, why? Urine ☐ Yes ☐ No Serology☐ Yes ☐ No

Does Participant have any health concerns related to IV Substance Use ☐ **Yes** ☐ **No**

Do any of the above conditions interfere with Participant attending detox? ☐ **Yes** ☐ **No**

Mental Health Status

	Yes	No		Yes	No		Yes	No		Yes	No
Depression			Schizophrenia			Anxiety			Mood Disorder		
Bipolar			Psychosis			OCD			Personality Disorder		
PTSD			Dementia			Phobia			Current Suicidal Ideation		
□ Unknown (If you are unsure if a diagnosis has been given or are not the Participant's regular doctor, check this box)											
Other (please be specific)											
Has medications been prescribed for any diagnosis above □ Yes □ No Please list all medications on Page 3 →											
Please indicate any issues that need to be addressed regarding Participant's mental stability when in detox:											

Substances Participant is Struggling With

Please use this section to indicate substances Participant has identified as problematic or wanting to make changes to their use.

Note: Participants withdrawing from opiates must be assessed by a practitioner able to prescribe OAT if required

Substance	How often	Length of history / Withdrawal experience	Estimated quantity	Method of use
Substance 1	How often	Length of history Withdrawal experience: Y □ N □	Estimated quantity	Method of use:
Substance 2	How often	Length of history Withdrawal experience: Y □ N □	Estimated quantity	Method of use:
Substance 3	How often	Length of history Withdrawal experience: Y □ N □	Estimated quantity	Method of use:
Substance 4	How often	Length of history Withdrawal experience: Y □ N □	Estimated quantity	Method of use:

Other Substances used:

(not indicated by participant as problematic or needing change)

Opiate Information

Does Participant use non-prescribed Opiates? Y □ N □	How frequently are Opiates used?	Is the practitioner completing this form able to prescribe OAT? **Y □ N □** (**If unable to prescribe**, Participant **must** be referred to a Physician who can both assess and prescribe opiate replacement therapy if needed before entry)	Has OAT been prescribed for Participant? Y □ N □ Please send OAT prescriptions to Brothers Pharmacy Phone: 204-586-2074 Fax:204-586-2458

Please list and send a separate prescription to Northway Broadway Pharmacy for all medications currently taken by Participant (except for methadone and suboxone). All prescriptions intended to be taken on unit including daily medication, over the counter medications, vitamins, or any needed medical supplies MUST be sent to Northway Broadway Pharmacy.

THE UNIT DOES NOT HAVE A SUPPLY OF STOCK MEDICATION ON HAND. PLEASE ENSURE ALL NECESSARY MEDICATIONS HAVE BEEN PRESCRIBED FOR 14 DAYS AND SENT TO THE PHARMACY FOR THE PARTICIPANT (THIS INCLUDES ANY OVER THE COUNTER MEDICATIONS THAT MAY BE NEEDED FOR STAY)

Medication Name	Directions	Medication Name	Directions	Medication Name	Directions

Additional Notes:

Participants should be instructed to **NOT** pick up these medications before detox because the prescription will be requested from the pharmacy after intake. If participant is on OAT, they should consume their dose prior to arrival.

Do you assess that this Participant is medically stable and can attend a Withdrawal Management program?
□ Y □ N □ Other (indicate why):____

Is there any additional information that we should know about this Participant? ______________________________
____

Physician/NP/PA Name: _________________________________ Phone: ___________________________

Address: _______________________________ After Hours Contact:______________________________

*******PLEASE NOTE, MEDICATIONS PRESCRIBED FOR WITHDRAWAL MANAGEMENT CAN ONLY BE USED WHILE IN THE PROGRAM. MEDICATIONS WILL NOT RETURNED TO PARTICIPANT UPON DISCHARGE AND WILL NOT BE AVAILIABLE FOR PICK UP (THIS INCLUDES PARTICIPANTS WHO HAVE SELF-PAID FOR MEDICATIONS)*******

Physician/NP/PA Signature: ____