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PLACE CLIENT STICKER HERE IF ADMITTED (WMS STAFF)

Withdrawal Management Services
Client Referral & Pre-Screening Form

Date: ___________________ Time: _________________ Catalyst Chart # (if applicable): ____________________

CLIENT INFORMATION	
Name (First & Last):	
DOB (DD/MM/YYYY):	
Birth Sex:	
Current Sex:	Preferred pronouns if disclosed by client: _________
Language:	
Phone:	( ) ☐ Is it okay to leave a message?
Full Address:	
If you have no fixed address, where are you staying?	
Health Card Number: (This is not mandatory for admission)	
Referral Source:	☐ PES ☐ ED (Circle: SCS, NFS, WS) ☐ NPC ☐ Outpatient Addictions ☐ OPMH ☐ Inpatient MH ☐ Client Self-Referral (*telephone*) ☐ Client Self-Referral (*in-person*) ☐ Other (Name/Agency) ___________________________________

ADMISSION CRITERIA

1. Are you looking for a safe space to withdraw from substances used? ☐ YES ☐ NO
2. Are you actively using substances and at risk for/currently experiencing withdrawal symptoms? ☐ YES ☐ NO
3. Are you seeking and agreeing to be admitted to WMS? ☐ YES ☐ NO
4. Are you seeking a safe space to help you create positive lifestyle changes to support you in your sobriety and recovery process? ☐ YES ☐ NO
5. Do you wish to maintain sobriety and recovery? ☐ YES ☐ NO
6. Are you looking for medical assistance to withdraw from substances used? ☐ YES ☐ NO
7. Are you currently suspended or restricted from any WMS or community care services? ☐ YES ☐ NO
   If yes, please provide details: _______________________________________

YES to (1), (2), (3), (4), or (5) are sufficient for admission; (6) and (7) may be YES or NO.

For Referring Agencies/Hospital Centres: If YES to (1), (2), (3), (4), or (5) please **fax WMS a copy of this completed referral form to 905-682-4749**, and WMS will call back within 24 hours to schedule an intake.

If referring from the **Emergency Department**, please contact WMS (905-682-7211) and our team will complete this intake form with the client over the phone.

- ➔ All client referrals and pre-screens must be reviewed for safety and suitability and approved for admission by the WMS clinical team.
- ➔ Priority for intakes will be given to Niagara Health patients to support a transfer of care and for NRP.

Dunham K, Mathew M, Cheema K, Vandewiel M, Jones L, Rivest K, Bonis J, Kahan M, Wyman J. Withdrawal Management Services Toolkit. Toronto, ON: META:PHI: 2024. www.metaphi.ca.

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SUBSTANCE USE

What substances do you use, how much, and what is the frequency of your use?

Substance	Amount Used	Last Use	Days used out of 30?
☐ Alcohol/alcohol substitutes Specify: ________________________			
☐ Amphetamines/other stimulants Specify: ________________________			
☐ Cocaine			
☐ Crack			
☐ Cannabis			
☐ Ecstasy			
☐ Opioids			
☐ Fentanyl			
☐ Hallucinogens			
☐ Heroin/Opium			
☐ Benzodiazepines			
☐ Tobacco			
☐ Glue & other inhalants			
☐ Other Specify: ________________________			

Do you have a history of past overdose(s)? ☐ YES ☐ NO

If yes, when/details: ____________________________

Have you previously received addiction treatment? ☐ YES ☐ NO

If yes, when/details: ____________________________

Do you have any other addiction concerns or activities, (i.e. sex or gambling)? ☐ YES ☐ NO

If yes, specify: __________________________________

EXCLUSION CRITERIA

If any of the following criteria are met, please refer the client to the appropriate service provider (i.e. emergency services).

☐ Poor airway/breathing/circulation/altered level of consciousness

☐ New cough, fever, vomiting, or diarrhea and/or at risk of dehydration (before the onset of withdrawal symptoms)

☐ Acute serious injuries requiring medical attention (i.e broken bones, head injuries)

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☐ Acute psychosis or mania, extreme agitation or confusion

☐ Inadequately controlled chronic psychiatric disorders

☐ Inadequately controlled diabetes

☐ Actively suicidal or homicidal ideation with plan, intent and means

☐ History of hallucinations or seizures when stopping substance use (*Note:* may be appropriate if NP present for admission)

☐ History of delirium tremens (DTs) (*Note:* may be appropriate if NP present for admission)

☐ Chronic medical conditions requiring significant medical monitoring or medical supplies (i.e. severe CHF, oxygen requirement, need for continuous cardiac monitoring)

☐ Use of alcohol substitutes (i.e. rubbing alcohol, Listerine)

☐ < 16 years of age

*Client admission may be appropriate after a medical assessment. If unable to admit, please encourage the client to return when acute concerns have been addressed.

If any of the following criteria are met, please flag this to the WMS team, so the nurse on-shift can review for clinical appropriateness for intake:

☐ Minor acute injuries (i.e. open sores, wounds, skin infections)

☐ 65+ years of age

☐ Have stopped medications for chronic illnesses within the last 60 days

☐ Missing medications for chronic or acute illnesses (i.e. insulin, blood pressure medication)

☐ Concurrent benzodiazepine and alcohol withdrawal

☐ History of seizures

If yes: On treatment? ☐ YES ☐ NO

Date of last seizure: ____

***All client intakes must occur when appropriate clinical staff are on-site.**

MEDICAL SCREENING

List all allergies, and severity of reaction:

____

____

____

Do you require an EpiPen? ☐ YES ☐ NO

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Dietary restrictions? ☐ YES ☐ NO

If yes, specify: ____

MEDICAL HISTORY

Please indicate any medical issues and surgical history.

☐ Diabetes (Insulin: ☐ YES ☐ NO)

☐ Kidney disease (kidney failure, stones, infection)

☐ Respiratory concerns (COPD, asthma)

☐ Cancer (Type: ________________ ☐ Resolved?)

☐ History of head injury

☐ Seizure disorder (epilepsy, withdrawal, overdose)

☐ Thyroid (high, low)

☐ Menstrual/menopausal difficulties

☐ Heart disease (heart attack, heart failure, pacemaker, atrial fibrillation, bypass)

☐ Sleep apnea (CPAP: ☐ YES ☐ NO)

☐ Liver problems (cirrhosis, hepatitis, liver failure)

☐ Chronic pain (fibromyalgia, nerve damage, etc.)

☐ High blood pressure

☐ Eating disorder

☐ Lice/Scabies

☐ Pancreatitis

☐ STI (Type: ______________________☐ Resolved?)

☐ Stomach concerns (reflux, ulcer, hernia)

☐ Other: ____

☐ Surgical procedures: ____

Chance of pregnancy? ☐ YES ☐ NO ☐ Not Applicable

If yes, who is the care provider: ____

Do you have concerns with:

☐ Lack of stable housing, unsafe housing, or being unhoused?
☐ Lack of regular access to food?
☐ Lack of access to healthcare?
☐ Any functional concerns that impact your ability to do activities of daily life?
- ☐ Memory or cognition
- ☐ Mobility
- ☐ Vision
- ☐ Hearing
- ☐ Falls/balance impairment

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Do you use any assistive devices and will you bring them to WMS? (i.e. oxygen, glasses, walker, dentures, prosthetics, hearing aids, etc.) ☐ YES ☐ NO

If yes, specify: ____

MEDICATION HISTORY

Please indicate any medications you are taking, or should be taking (prescription, over-the-counter, supplements, vitamins, inhalers, topicals, and samples).

MEDICATION	DOSE	ROUTE	FREQUENCY	REASON	TAKING AS PRESCRIBED?
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO

Methadone/Opioid replacement therapy? ☐ YES ☐ NO

If yes, specify:

☐ Dose: ____

☐ Prescriber: ___________________________________

☐ Pharmacy: ____________________________________

☐ Last Dose (Date/Time): ________________________

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MENTAL HEALTH HISTORY

Received treatment for mental health:	☐ Currently	☐ Within the past 12 months	☐ Within Lifetime
Received medication for mental health:	☐ Currently	☐ Within the past 12 months	☐ Within Lifetime
Psychiatric Admissions (inpatient/admitted to hospital):	☐ Currently	☐ Within the past 12 months	☐ Within Lifetime
Previous suicide or self-harm attempts:	☐ YES If yes, when:	☐ NO ____________________________	
Current suicidal thoughts or intent?	☐ YES If yes, specify:	☐ NO ____________________________	
Current thoughts or intent to self-harm?	☐ YES If yes, specify:	☐ NO ____________________________	
Current thoughts or intent of harming others?	☐ YES If yes, specify:	☐ NO ____________________________	

DIAGNOSED MENTAL HEALTH CONDITIONS

Have you been diagnosed with any mental health conditions?

☐ Anxiety	☐ Depression
☐ Panic Disorder	☐ PTSD
☐ Schizophrenia	☐ ADHD
☐ Bipolar Disorder	☐ Obsessive Compulsive Disorder
☐ Borderline Personality Disorder	☐ Oppositional Defiant Disorder
☐ Autism Spectrum	☐ Cognitive Concern/Delay

☐ Other (Specify: ____)

Additional comments/details:

____
____
____

INTAKE REVIEW

Has the client been informed of the WMS guidelines, policies, regulations, and expectations? ☐ YES ☐ NO

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- ➔ **Behavioural expectations:** Niagara Health has a no-tolerance policy for abuse of any kind towards both staff and other clients. This includes:
  - No verbal abuse
  - No violence
  - No harassment
  - No racism
  - No discrimination
- ➔ **Smoking policy**: Clients will be encouraged and offered NRT at WMS. However, clients are permitted to smoke cigarettes at designated smoking times and from their own supply, which will be safely stored by WMS staff. You will be required to review and sign the WMS smoking agreement on admission.
- ➔ If deemed clinically stable by nursing staff, clients are **required to attend all in-house meetings and programming**.
- ➔ You and your belongings will be searched on admission and at any time during your stay, including the use of a wand for metal detection. **No drugs/paraphernalia/weapons/sharps of any kind are permitted**. Staff will dispose of these accordingly if found.

Has the medication policy and process been explained? ☐ YES ☐ NO

- ➔ Clients are to bring all medications in their original labelled containers.
- ➔ Staff are to administer all medications. The client's home medications will be stored securely by WMS staff to dispense as required.
- ➔ Clients are to adhere to standardized medication administration times. Staff will notify you of the medication pass schedule.
- ➔ The NP will review your medication history to determine the appropriate continuation, dose, and use of prescribed medications as required.

Has the client passed infection control screening? ☐ YES ☐ NO

If no, specify: ____

How will you get here? ____

Can your ride stay while we check you in? ☐ YES ☐ NO

Will you have a ride to pick you up after discharge? ☐ YES ☐ NO

If not, what is your current plan for discharge? ____

Are you being transferred from another facility? ☐ YES ☐ NO

If yes, what is the reason for your visit to that facility? ____________________________________

Will you be transferred back after your WMS stay? ☐ YES ☐ NO

If not, has the referring agency disclosed this to the client (mandatory)? ☐ YES ☐ NO

***If being discharged from supportive/recovery housing or community programming, the discharging agency must disclose this to the client before being admitted to WMS.**

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Outcome of phone call referral:

☐ Refer to the most appropriate service (Specify: ____)

☐ Pending a WMS follow-up call to schedule an intake date/time

By signing, you are agreeing that all of the above information is accurate and that the client agrees to abide by all WMS guidelines, policies/procedures, and expectations.

Form completed by (First/Last): ___________________________

Signature/Status: ___________________________________

Date: _____________________________ Length of phone call (WMS staff only): ______________________

☐ Client to staff referral ☐ Staff to staff referral

*For clients being referred to WMS from a healthcare facility (i.e. inpatient/outpatient services), please ensure to fax us (905-682-4749) a copy of the following, in addition to this referral form:

☐ CIWA/COWS scoring sheets

☐ Medication Administration Record

☐ BPMH

☐ Face sheet of clinical record

After reviewing your WMS referral application staff will contact you within 24 hours to discuss and schedule an intake. If you do not hear back from us within 24 hours, please call us back (905-682-7211).