IMPORTANT – If you are seeking Withdrawal Support Services (detoxification) for your opioid use, abstinence is not recommended. Opioid Agonist Treatment (OAT) is recommended as a safe and effective way to treat your opioid addiction and can be provided to you by a RAAM clinic or other providers in your community.

An abstinence-based approach to opioid addiction can place you a risk of overdose or death. You are welcome to attend a RAAM clinic to discuss your options.

Community Health and Housing ASSOCIATION

WITHDRAWAL SUPPORT SERVICES APPLICATION FORM

Application to attend the Withdrawal Support Services (WSS) facility at **Joshua Jacks 19 – 13th St., Brandon**

Inquiries 24hrs: 204-727-4557 Fax Number: 204-727-4638 Admission intakes are Monday through Friday between the hours of 8:30 am to 6:00 pm

Withdrawal Support Services (WSS) provides voluntary non-medical services to clients with substance use disorder. The length of stay is based on the client's need (up to a maximum of 30 days). A client centered plan will be developed in order to assist the client in their recovery.

A MEDICAL CLEARANCE INCLUDING PRESCRIPTIONS IS REQUIRED PRIOR TO CLIENT ATTENDING WSS FOR INTAKE ASSESSMENT. ACCEPTANCE/NON-ACCEPTANCE INTO WSS WILL BE DETERMINED FOLLOWING THE WSS INTAKE ASSESSMENT.

Note to Practitioner: Medications need to be in blister packaging

Part 1

Please note Part 1 of this application may be completed by referral agency and/or client, whereas Part 2 must be completed by a Physician or Nurse Practitioner.

CLIENT INFORMATION: Please print clearly.	**Date of Application: ______________________** **Time of Application: ______________________**		
FIRST NAME:	**MIDDLE NAME:**	**LAST NAME:**	
Other names known by:	Gender: ☐ M ☐ F ☐ T ☐ Other	Date of Birth: (Day/Month/Year)	Age:
Current Address:	Home Phone Number:	Cell Phone Number:	Other:
MB Medical: *9 digit:* *6 digit:*	Treaty? ☐ Yes ☐ No If yes, Treaty #: Band:		
Emergency Contact Person (*name and phone number*):			
REFERRAL SOURCE:			
Name:	Agency:	Date:	
Last Visit:	Address:	Phone:	

Phone:	Email:

Are there any important appointments that may occur during WSS admission, requiring advance planning with WSS staff? ☐ Yes ☐ No

Note: In order to attend any appointments, clients need to be escorted to and from the appointment.

CURRENT LIVING SITUATION:

☐ Living alone	☐ Living in transitional housing	☐ At risk of homelessness
☐ Living with family/friends	☐ Shelters	☐ Hospital
☐ No fixed address	☐ Living in rural area	☐ Living out of province
☐ Incarceration (just released)	☐ Residential Treatment Program	☐ Crisis Unit
☐ Other:		

EMPLOYMENT STATUS:

☐ Unemployed ☐ Employed:____ ☐ Disability

Source of Income (specifically for medications): ☐ EIA ☐ Insurance ☐ Pension ☐ Trustee ☐ Self Pay ☐ Other:

Name and contact information of worker if applicable:

LEGAL INFORMATION:

Is there a No Contact Order (NCO), Peace Bond, or Restraining Order in place?

☐ Yes ☐ No

If yes, please provide details?

Are there any outstanding legal issues/court dates during WSS admission? ☐ Yes ☐ No

If yes, please provide details:

SUBSTANCE USE INFORMATION:

Which substance(s) do you need Withdrawal Support Services for?

First Substance:	First Use?	Last Use?	Amount used?	How often?
Second Substance:	First Use?	Last Use?	Amount used?	How often?
Third Substance:	First Use?	Last Use?	Amount used?	How often?

Injection drug use? ☐ Yes ☐ No	Smoke tobacco? ☐ Yes ☐ No (Secured smoking area is available)

OPIOID ASSESSMENT INFORMATION:

Use Opioids? ☐ Yes ☐ No	Feels sick when usage of opioids stopped? ☐Yes ☐ No
Prescribed Suboxone or Methadone? ☐ Yes ☐ No If yes, please name the Primary Care Prescriber?	
Is there interest in Opioid Agonist Therapy? ☐ Yes ☐ No	

*****If Opioid Agonist Therapy (OAT) is applicable, please arrange for assessment via Rapid Access to Addiction Medicine (RAAM), Manitoba Opioid Support and Treatment Clinic (MOST), Primary Care Outpatient Clinic (PCOC) or Primary Care Provider. *****

Is there interest in attending a treatment program after WSS? ☐ Yes ☐ No ☐ Maybe
If yes, which one:

☐ AFM ☐ BHF ☐ Anchorage ☐ Tamarack ☐ UGM ☐ Pritchard House ☐ Other please state:

SAFETY/RISK INFORMATION:

History of suicidal thoughts? ☐Yes ☐ No If yes, when:	
Current suicidal thoughts? ☐Yes ☐ No If yes, is there a plan? ☐Yes ☐ No If yes, what is the plan:	
Is there intent to act on the plan? ☐Yes ☐ No If yes, please provide details:	
History of suicide attempts? ☐ Yes ☐ No If yes, how many times: ______________________ When was the last time: ______________________	History of self-harming? ☐ Yes ☐ No If yes, how often: _______________________ When was the last time: __________________ Method: ________________________________
Concerns for or exhibited signs of violence/aggression? ☐ Yes ☐ No If yes, please elaborate:	

WITHDRAWAL SUPPORT SERVICES

Note client to retain this list for their use

What To Bring:

Medications in Blister Pack

Comfortable clothing – clothing with profanity/drug/alcohol promotion is not permitted

Socks

Underwear

Brush/comb

Non-alcohol toiletries (alcohol ingredients are not permitted)

Winter jacket and appropriate footwear (when applicable for season)

Medical card (if lost WSS staff may assist with an application for a replacement card) Reading

material

Information on upcoming appointments i.e. Doctor, Court, etc.

What Not To Bring:

Money not recommended, however if brought will be safely secured for duration of the stay

Cell phone not recommended, however if brought will be safely secured for duration of the stay

Medications not prescribed and not packaged in Blister Pack

Over the counter, off-the-shelf medications/home remedies

Food/beverages

Jewelry not recommended and if brought is at your own risk

Lighters (we will provide)

Cologne/perfume (Scent free environment) Weapons/Drug

paraphernalia

Note* Space is limited so we ask that you only bring what is necessary. Laundry facilities are available for your use. WSS is not responsible for personal belongings.

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Part 2

MEDICAL CLEARANCE FORM

In addition to the completed Application Form (Part 1) clients considering admission to the Withdrawal Support Services (WSS) must have the following Medical Clearance (Part 2) completed within 7 days prior to the WSS intake assessment.

To be completed by a Primary Care Provider ****PLEASE PRINT****

Date:____________________ ***This form will be valid for 7 days:***____________________
Expiry time and date

Client Name:____________________ **DOB:**____________

PHIN #: ________________ **MHSC #:**____________

Is this client a regular patient of yours? ☐ Yes ☐ No Last seen by you on what date:____________	Is this client pregnant: ☐ Yes ☐ No # of weeks ____ If yes, is the client receiving prenatal care? ☐ Yes ☐ No
Are you aware if client lives with any of the following:	
Seizures: ☐ Yes ☐ No	**Diabetes:** ☐ Yes ☐ No
Asthma: ☐ Yes ☐ No	**Allergies:** ☐ Yes ☐ No
***Epi Pen Needed:** ☐ Yes ☐ No	**Other:**

Has a lice/scabies check been completed? ☐ Yes ☐ No
Does this client have lice/scabies? ☐ Yes ☐ No
Is this client known to have a history of TB? ☐ Yes ☐ No **If yes, is client contagious**? ☐ Yes ☐ No
If client is agreeable please consider taking this opportunity to conduct STBBI testing? ☐ Yes ☐ No

If this client needs an Epi pen or equivalent it must be prescribed.
Will any of the above checked medical conditions impact the client attending Withdrawal Support Services?
☐ Yes ☐ No
If yes, please explain:

Physical Examination: *(check each item)*

Please flag medical conditions that may require attention during WSS admission.
(WSS has access to a 7th Street Health Access Centre Community Nurse on an as needed basis for non-emergency and non-urgent conditions).

	Normal	Abnormal	Comments	
Respiratory System				
Cardiovascular				
Skin Integrity				
Gastrointestinal				
General	Pulse	Blood Pressure	Temp	O2 Sat
Other:				

A Urine Substance Screen is required for confirmation of what substances are in the client's system.

Urine sample was conducted on (date): _______________	The following substances were found in the urine sample: 1)___________________________________ 2)___________________________________ 3) ____

Pease list any additional substances if any:

Mental Health Status:

Are you aware the client is living with any of the following:

☐ Depression	☐ Generalized Anxiety	☐ Personality Disorder
☐ Bipolar Disorder	☐ Social Anxiety	☐ Seasonal Affective Disorder
☐ PTSD	☐ OCD	☐ Phobia
☐ Schizophrenia	☐ Psychosis	☐ Neurocognitive Disorder

Is there a history of methamphetamine psychosis? ☐Yes ☐ No

☐ Other (please be specific):

☐ Unknown (if you are not this client's regular Primary Care Provider and do not know if they have a diagnosis please check this box)

Current Mental Health Concerns:

Medications:

Please provide a list of the client's regular medications, including all over the counter, off the shelf, vitamins and herbal preparations:

Please see below for PRN medications specific to withdrawal symptom management, as WSS has no stock supply to provide.
All PRNs must be blister packed separately from regular medications.

Medication Name	Directions		Medication Name	Directions
Antiemetic (Gravol)				
Analgesic				
Anti-diarrheal (Imodium)				
Multivitamin				
Thiamine (Alcohol withdrawal)				
Other Medications				

Medication Funding Source: ☐ EIA_______ ☐ Treaty: #________________ ☐ Self Pay ☐ Other (i.e. insurance)

**** IS BUPRENORPHINE(SUBOXONE)/METHADONE CURRENTLY PRESCRIBED? ****

☐ Yes ☐ No

If client is presenting with opioid dependency please have Primary Care Provider initiate OAT treatment or refer to Rapid Access to Addictions Medicine (RAAM), Manitoba Opioid Support and Treatment Clinic (MOST) or Primary Care Outpatient Clinic (PCOC) for treatment prior to WSS intake interview.

Please note that OAT medications will NOT be given to client when discharged/leave.

Please provide a 7 day prescription with 3 repeats for all medications *(one week supply delivered at one time)*.

Prescription written and forward to a Brandon Pharmacy with delivery services.
Pharmacy Name:

***Please indicate on the prescription that all medications are to be provided in BLISTER PACK format. ***

MEDICAL CLEARANCE STATUS:	
Is the client medically stable? ☐ Yes ☐ No	**Is the client psychiatrically stable?** ☐ Yes ☐ No
Has the client been assessed as appropriate for Withdrawal Support Services? ☐ Yes ☐ No	**Is the client voluntarily seeking Withdrawal Support Services?** ☐ Yes ☐ No

Medical Clearance for Non-Medical Withdrawal Management Services

I have assessed the above-named client and have clinically determined they are medically stable for intake into Withdrawal Support Services at Community Health and Housing Association Westman Region which provides non-medical services.

______________________________ ______________________________
Please Print Name of Primary Care Provider Signature

______________________________ ______________________________
Date Phone Number

WSS OFFICE USE ONLY BELOW THIS LINE

WSS staff person completing/reviewing application: (Please Print)

☐**New Client or** ☐ **Previous Client/File Number: If this client has stayed in any program with CHHA, please indicate the date and the last program stay: Date:**

Date received:____ **Time received:**____

Date: ______________________________**and time** _________________________**of Intake Interview**

Action Taken: ☐ **Admitted**

☐ **Re-directed to where:**____

ALL UNUSED MEDICATION WILL BE GIVEN TO THE CLIENT TO TAKE WITH THEM UNPON DISCHARGE OTHER THAN OAT MEDICATIONS!