Youth Recovery House Withdrawal Management Referral

Email: info@thebridgeservices.ca Phone: (250) 763-0456 ext. 2503 **Fax :** (250) 717-6395

Referrer Details:

Date: _____

Referring Person Name: _____

Organization/office: _____

Telephone: _____

E-mail Address: _____

COVID – 19 Screening:

- ☐ Fever >38
- ☐ Cough – New or Increased
- ☐ Recent Travel outside of Country
- ☐ Exposed to known infected person
- ☐ CPAP Machine
- ☐ COVID/ Isolation info Explained

Individual / family details

Participant Name: _____ DOB: _____ Age: _____ Gender: _____

Participant Phone: _____ Ethnicity: _____ Pronouns:_____

Parent/Legal Guardian: _____Contact Information: _____

MCFD Legal Status: (if Applicable) _____

Other Professionals Involved:

Primary Service Provider & Role: _____ Phone: _____

Physician: _____ Phone: _____

Name & Role: _____ Phone: _____

In an emergency contact:

Name	Home Telephone	Work Telephone	Cell Phone
_____	_____	_____	_____

Care Card #_____ **Allergies**: _____

Medications/special diet: _____

Medical concerns/diagnosis: _____

_____

Dr. Diagnosed or Suspected Mental Health/ Self-Harm/ Suicide attempts/ Brain Injury:

_____

_____

ALCOHOL: **GHB?** Yes ☐ No ☐	**STIMULANTS:**	**OPIATES:**	**BENZODIAZEPINES:**
Daily? Yes ☐ No ☐ How much per day/week?	Regular Use? How Much per day?	Regular Use? How much Per day?	Regular Use? How much Per day?
Mouthwash or Solvents?	Injects?	Injects?	Hx of OD?
History of Seizures or DT's?	Chest Pain with Use?	Hx of OD? Narcan?	Hx of psychosis?
		Hx of Severe W/D?	Hx of seizure?
		Interested in OATS? Dr. Support on D/C?	Hx of serve W/D?

Participants referred to YRH Withdrawal Management MUST have a confirmed Transition Exit Plan prior to admission.