COMMUNITY HEALTH AND HOUSING ASSOCIATION
WITHDRAWAL SUPPORT SERVICES

APPLICATION FORM

Applying to attend the WSS facility at **1233 Rosser Ave., Brandon, MB**

Inquiries 24hrs: 204-727-4557 **Fax Number: 204-727-4638**

Admission intakes are Monday through Friday between the hours of 08:30-18:00

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). Client will participate in development of treatment plan which will include assistance in next steps.

A MEDICAL CLEARANCE INCLUDING PRESCRIPTIONS IS REQUIRED PRIOR TO CLIENT ATTENDING WSS FOR INTAKE ASSESSMENT. AN INTAKE ASSESSMENT BY WITHDRAWAL SUPPORT SERVICES WILL OCCUR PRIOR TO ADMISSION.

Note to Primary Care Provider: Medications need to be in blister packaging.

Part 1:

Client Information: Please print clearly Date and time of Application: ___________________________

FIRST NAME ***(legal name):***	**MIDDLE NAME:**		**LAST NAME:**
Other names known by:	Gender: ☐ M ☐ F ☐ T	Date of Birth:	Age:
MB Medical: *9 digit*	*6 digit*	Treaty? ☐ Yes ☐ No If yes, Treaty # Band:	

Employment Status: ☐ Unemployed ☐ Employed:___________________________☐ Disability

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

Please provide detailed info (i.e. EIA worker name/phone/office)

Emergency Contact Person (*Name and Phone number*)

Can messages be left with this person? ☐ *Yes* ☐ *No*

Previous Substance Withdrawal Program Involvement: ☐ Yes ☐ No If yes, when and where___________________

Does client have any important appointments that may occur during their stay, requiring advance planning with WSS staff?
☐Yes ☐ No ***Note: leaving the program is not permitted, unless released to responsible escort**

Do you plan to attend a treatment program after WSS? ☐ Yes ☐ No ☐ Maybe If yes, which one:

☐ AFM ☐ BHF ☐ Anchorage ☐ Tamarack ☐ UGM ☐ Pritchard House ☐ Other ____________________________

What is your current living situation:

☐ Safe housing	☐ Living in transitional housing	☐ Living on the street
☐ Living with family	☐ Living with friends	☐ Common shelter user
☐ At risk of homelessness	☐ Living in rural area	☐ Living out of Province
☐ Was in hospital	☐ Currently in a Treatment Program	☐ Crisis Unit
☐ Jail (just released)	☐ Other: ___________________________	

Referral Source: *(check all that apply)*			
☐	Self Initiated	☐	Hospital
☐	Treatment Program *(which one)*	☐	Community Agency *(which one)*
☐	Justice	☐	CFS Mandate/Legal Mandate
☐	EIA	☐	Mental Health Services
☐	First Nation Community Health	☐	AFM
☐	Other		

SUBSTANCES CURRENTLY USING

Please use this section to let us know what types of substances you are using (i.e alcohol/drugs)

Which substance(s) do you need withdrawal support services for?

First Substance of Choice		**How often do you use this?**
Second Substance of Choice		**How often do you use this?**
Third Substance of Choice		**How often do you use this?**

Injection drug use? ☐ Yes ☐ No	Do you smoke tobacco? ☐ Yes ☐ No Secured smoking area available

OPIOID ASSESSMENT INFORMATION

Use Opioids? ☐ Yes ☐ No	Feels sick when you stop using opioids? ☐Yes ☐ No

Prescribed Suboxone or Methadone? ☐ Yes ☐ No If yes, Primary Care Prescriber name?

Is there interest in Opioid Agonist Therapy?

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

MEDICAL INFORMATION

Is there a regular Primary Care Provider? ☐ Yes ☐ No If yes, Name: ____________	Location/phone**:**	Last Visit:

Is client pregnant? ☐Yes ☐ No If yes, how many weeks? ________

Does client believe she may be pregnant? ☐ Yes ☐ No

Has client had any suicidal thoughts in the past 7 days? ☐ Yes ☐ No If yes, last time:

Does client use suicidal ideation to help cope? ☐ Yes ☐ No If yes, how often:

Has client had any suicide attempts? ☐Yes ☐ No If yes, how often/last time:	Does client have a history with self-harm? ☐Yes ☐No If yes, how often/last time:

LEGAL INFORMATION

Is there a No Contact Order (NCO), Peace Bond, or Restraining Order against anyone or against you? ☐ Yes ☐ No
If so, provide details?

Is there any outstanding legal issues/court dates that will happen while you are in WSS? ☐ Yes ☐ No

Concerns for or exhibited signs of violence/aggression ☐ Yes ☐ No If yes, please elaborate:

Date:	Referral Source:
Agency:	Address:
Phone:	Fax:
Email:	

WSS OFFICE USE ONLY BELOW THIS LINE

WSS staff person completing/reviewing application: ___________________________________

☐ New Client or ☐ Existing Client / File Number: ____

If this client has stayed in any program at WSS please indicate the last program stay:________________Date: ____________

Notes:

Date and time WSS received: ____________________________________

Date and time WSS of Intake Interview: ___________________________

Disposition: ☐ Admitted
☐ Re-directed to where _________________________

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MEDICAL CLEARANCE FORM

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Part 2:

In addition to the completed Application Form (Part 1) clients considering admission to the Withdrawal Support Services must have the following Medical Clearance (Part 2) within 72 hours prior to intake assessment by Withdrawal Support Services (WSS).

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

Date:_______________ *This form will be valid for 72 hours:*_______________
Expiry time and date

Client Name:_______________ **DOB:** _______________

PHIN #: _______________ **MHSC #:** _______________ **Gender:** ☐ **M** ☐ **F** ☐ **T**

Is this client a regular client of yours? ☐ Yes ☐ No **Last seen by you on what date:**	Is this client pregnant: ☐ Yes # of weeks____ ☐ No If Yes is the client receiving prenatal care? ☐ Yes ☐ No

In the past 30 days what substances (i.e. drugs, alcohol) has this client been using:

Substance	How Much	How Often	Last Use

Does this client have a current occurrence and/or history of the following:

	Yes	No		Yes	No		Yes	No
Seizures	☐	☐	**Diabetes**	☐	☐	**Asthma**	☐	☐
Allergies	☐	☐	***Epi Pen needed**	☐	☐			
Other:								

Has a lice/scabies check been completed? ☐ Yes ☐ No **Has the client been screened for STBBIs**? ☐ Yes ☐ No
Does this client have TB? ☐ Yes ☐ No

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

Physical Examination				
Check each item	**Normal**	**Abnormal**	**Comments**	
Respiratory System				
Cardiovascular				
Skin Integrity				
Gastrointestinal				
General	**Pulse**	**Blood Pressure**	**Temp**	**O2 Sat**
Other:				

MENTAL HEALTH STATUS: Has this client been diagnosed with any of the following:

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

Have you had any suicidal thoughts in the past 7 days ☐Yes ☐No If yes, last time:	
If you answered yes to suicidal ideation, do you have a plan? Do you have intent to act on your thoughts?	
Have you had any suicide attempts ☐Yes ☐No If yes, how often/last time:	Do you have any history with self-harm □ Yes □No If yes, how often/last time:
Current Mental Health Concerns:	

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

Please see below for PRN medications specific to withdrawal symptom management, as WSS has no stock 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) or Primary Care Outpatient Clinic (PCOC) for treatment prior to WSS intake interview.

Prescription(s) written and forward to a Brandon Pharmacy

☐ Pharmacy Name: __________________________

Provide 10-day prescription with 2 repeats for all medications
(Arrangements will be made for delivery to WSS once admitted)

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

Is the client medically stable?

☐ **Yes** ☐ **No**

Is the client psychiatrically stable?

☐ **Yes** ☐ **No**

Is there a history of methamphetamine psychosis?

☐ **Yes** ☐ **No**

Is the client voluntarily seeking Withdrawal Support Services?

☐ **Yes** ☐ **No**

Has the client been assessed as appropriate for Withdrawal Support Service?

☐ 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.

______________________________	______________________________	______________
Primary Care Provider (Please Print)	Signature	Date

____

Phone Number

****PLEASE NOTE, UPON DISCHARGE, ALL UNUSED MEDICATION WILL BE RETURNED TO THE PHARMACY ****