



# NARSF TRANSITIONS PROGRAM MEDICAL SCREENING FORM

Physician: PLEASE RETURN THIS FORM TO YOUTH / FAMILY

Youth/Family: PLEASE ensure this form is received by Transitions Program Staff prior to admission to detox

Date: \_\_\_\_\_ Youth Name: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

PHN: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Please circle whether youth will be attending a **WITHDRAWAL MANAGEMENT** or **SUPPORTIVE RECOVERY** carehome.

Please highlight any medical concern that should be considered as the youth will be withdrawing from substances and staying at a non-medical detox or supportive recovery care home setting. Typical length of stay in the Transitions Withdrawal Management detox is 7-10 days and if admitted to Supportive Recovery 1-3 months. Please circle yes or no and give details as needed.

**Confirm the drug(s) the client will be detoxing from:**

**Drug(s):** \_\_\_\_\_ **Last Use:** \_\_\_\_\_ **Length/Method of Use:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Blood Pressure:** \_\_\_\_\_ **Temperature:** \_\_\_\_\_ **Heart Rate:** \_\_\_\_\_ **bmp**

**Any Known Allergies:** \_\_\_\_\_

1) Do you believe the youth can safely withdrawal in a non-medical detox care home or stay in a supportive recovery carehome? Yes No

If not, please explain why? \_\_\_\_\_

2) Are you prescribing any withdrawal management medication? Yes No

If yes, please provide details: \_\_\_\_\_

3) Are you prescribing the use of any over the counter medications? Specifically, which medications? \_\_\_\_\_ Yes No

4) Are there any OTC medications that cannot be administered to youth according to label recommendations and do you have any specific recommendations for use?  
\_\_\_\_\_

5) Does the youth have any presenting **MEDICAL** concerns that would intensify any health and/or safety issues while in a family care home/non-medical detox or supportive recovery carehome (such as: history of seizures, history of serious withdrawal symptoms, asthma, respiratory problems, diabetes, etc.)? Yes No

If yes, please provide details: \_\_\_\_\_

6) Does the youth have any presenting **MENTAL HEALTH** concerns that would intensify any health and/or safety issues while in a family care home/non-medical detox or supportive recovery carehome (such as: suicide ideation, previous suicide attempts, severe depression, eating disorders, etc.)? Yes No

If yes, please provide details: \_\_\_\_\_

7) Is youth taking medication for any of the above conditions mentioned in # 5 or #6? Yes No

What medications are being prescribed and for which specific condition: \_\_\_\_\_

8) Is the female youth pregnant or has she missed more than 1 period in the past 6 months? Yes No

9) If the youth is pregnant, can the client withdrawal safely in a non-medical detox or participate in a supportive recovery carehome? Yes No

Physician: \_\_\_\_\_ Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_