



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: _____