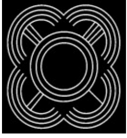

NARSF TRANSITIONS PROGRAM MEDICAL SCREENING FORM

Physician: PLEASE RETURN THIS FORM TO YOUTH / FAMILY
Youth/Family: This form must be received by Transitions Program Staff prior to admission

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 Care Home.

Confirm the substance(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:
____

Please highlight any medical concern that should be considered as the youth will be withdrawing from substances in 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 NA, Yes or No and give details as needed.

1) Do you believe the youth can safely withdrawal in a **non-medical** detox care home or stay in a supportive recovery Care Home? 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 allowing the use of any over the counter medications / vitamins / supplements? Yes No

   If yes, please complete the attached OTC form.

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 non-medical detox or supportive recovery Care Home (such as: history of seizures, history of serious withdrawal symptoms, asthma, respiratory issues, 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 non-medical detox or supportive recovery Care Home (such as: suicide ideation, 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? NA Yes No

   If yes, what medication(s) are being / have been prescribed and for which specific condition:

   ____

8) Is the youth capable and competent to utilize inhalers, epi pen, diabetic supplies, etc. as prescribed? NA Yes No

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

10) If the youth is pregnant, can they withdrawal safely in a non-medical detox or participate in a supportive recovery Care Home? NA Yes No

Physician: ____________________________ Signature: ________________________________ Date: ________________________