Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

* D 0 2 3 2 A *

Client/Patient ID Label

INTAKE MEDICAL - GTA
ADDICTIONS PROGRAM (IDRS)

Client/Patient Name:_____ Health Record #:_____
(Last Name, First Name)

Unit/Clinic/Service:_____

Client/Patient Date of Birth: _____
(dd/mm/yyyy)

Attn :_____(Therapist) Date:_____
(dd/mm/yyyy)

TO BE COMPLETED BY THE CLIENT'S PHYSICIAN or NURSE PRACTITIONER

Physician/RNEC name:_____ Physician/RNEC phone number:_____
(Last Name, First Name)

Please indicate which group your client/patient would like to attend:

☐ Integrated Day/Res group –- Fax: 416-595-6619

☐ African Descent Day/Res group – contact x7034 – Fax: 416-425-6001

☐ Cocaine group - contact x7075 – Fax: 416-595-6619

☐ Women's Only group - contact x7057 or x7037 – Fax: 416-425-6001

☐ Aboriginal group – contact x 7657 – Fax: 416-583-1219

☐ Spanish group – contact – 7046 –Fax: 416-425-6001

☐ Rainbow Service: Fax: 416-583-1216
☐ Gay Men's group - contact x7066
  ☐ LGBT – contact x7043

Please note: for the Specialty groups Client/Patient and/or Referring Agencies need to contact the group to inquire about availability.

Name of Physician or Nurse Practitioner:

Address:

Telephone number:_____**Fax Number:** _____

Date: (dd/mm/yyyy) _____

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Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

Part 1: DRUG AND ALCOHOL HISTORY

Please provide detailed information about the following:

Substance	N/A	Amount per day	Days of use per month	Last date of Use / ONGOING
Alcohol				
Heroin				
Methadone				
Other opioids				
Barbiturates				
Benzodiazepines				
Other sedatives/ Hypnotics/tranquilizers				
OTCs(gravol,benadryl)				
Cocaine				
Amphetamines				
Cannabis				
Hallucinogens				
Inhalants				
Nicotine				
Other				

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Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

	Y	N
Can your client/patient maintain abstinence for seven days prior to admission?		
Is your client/patient using opiates on a daily basis?		
Is your client/patient using benzodiazepines on a daily basis?		
Is there a history of withdrawal seizures?		
Has the client/patient ever required medication-assisted withdrawal? If yes, please provide date:_____		

PAST MEDICAL HISTORY (including psychiatric diagnoses-if any)

_____

_____

_____

_____

☐ Does your client/patient take any prescribed or over-the-counter medication, which they will require during their treatment program? If yes, please provide details:*

_____

_____*

_____

***Please advise client/patient to bring enough of their medications to last throughout their stay.**

*** Please also have client/patient go to pharmacy to obtain a MED CHECK and fax back with application.**

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ADDICTIONS PROGRAM (IDRS)

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

☐ Allergies:_____

_____

_____

☐ Is your client/patient a current suicide risk? ☐Yes ☐No

If yes, comment:

_____

_____

_____

☐ Is there a past history of suicidal ideation or self-harm? ☐Yes ☐No

If yes, when _____

Details _____

☐ Has client been hospitalized for any psychiatric issues (including ER)?

☐Yes ☐No

If yes, when_____

Details _____

☐ Will your client'/patients mental status allow for participation in group therapy?

☐Yes ☐No

☐ Is this client/patient currently under the care of a psychiatrist?

☐Yes ☐No

If yes, name and reason:

***Please attach a psychiatric assessment and/or consult notes of diagnosis**

* D 0 2 3 2 B *

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ADDICTIONS PROGRAM (IDRS)

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

REVIEW OF SYSTEMS

	N	ABN	Details
General:			
Skin:			
Head:			
Eyes:			
Nose:			
Mouth & Throat:			
Respiratory:			
Cardiovascular:			
Gastrointestinal:			
Genitourinary:			
Gynecological:			
Endocrine:			
Musculoskeletal:			
Neurological:			

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ADDICTIONS PROGRAM (IDRS)

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

PHYSICAL EXAMINATION:

General Appearance	
Vital Signs	
Skin	
Lymph Nodes	
Eyes	
Ears	
Mouth & Throat	
Neck	
Chest	
Heart	
Breast	
Abdomen	
GU	
Musculoskeletal	
Neurological	

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ADDICTIONS PROGRAM (IDRS)

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

LABORATORY INVESTIGATIONS:

Please send copies of current laboratory, radiological reports, & consultation notes (recent: within 3 month)

- ☐ CBC; a) LFT: GGT, AST, ALT, AlkPhos, bili; b) amylase, c) KFT: creatinine; d) lytes: Na, K, Cl, Mg, Phos, Ca with TPr and Alb; e) PT/INR; f) blood sugar; g) BHCG for women of childbearing age
- ☐ Hepatitis Screen for A, B, C
- ☐ HIV: (following counseling and consent) with recent CD4 and viral load if HIV+.
- ☐ TB skin test within 3 months Date (dd/mm/yyyy): _____
  - o Result: _____
  - o Initial: _____
- ☐ CXR if TBST positive or other clinical indication
- ☐ ECG if:
  - ☐ Over forty
  - ☐ Injection drug user
  - ☐ Uses cocaine, crack, amphetamines, ecstacy, or other stimulant
  - ☐ Has cardiovascular disorder or symptoms
  - ☐ Frail or otherwise clinically indicated

_____
Signature

_____
Print Name and Credentials

Date: _____
(dd/mm/yyyy)

Time: _____
(24 hour clock)

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INTAKE MEDICAL - GTA
ADDICTIONS PROGRAM (IDRS)

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

INFORMATION SHEET
ADDICTIONS PROGRAM (Integrated Day Residential Service)

Client/Patient Name: _____ Health Record #: _____

Clients entering the residential program are required to be abstinent from psychoactive drugs, namely alcohol, benzodiazepines, opiates, barbiturates and cannabis.

Withdrawal management can usually be accomplished in an outpatient setting through the care of a physician (for example a slow taper from benzodiazepines). In-patient withdrawal management is available (prior to starting program) for those clients whose medical status requires closer medical supervision.

All potential addictive psychoactive medications (even if prescribed) will be discontinued (or tapered) while at the Centre for Addiction and Mental Health if the client comes to us for withdrawal management from any other drug (for example, a client coming for detoxification from alcohol will be tapered from benzodiazepines).

_____
Signature of Client

Date: _____
dd/mm/yyyy

If you have any questions regarding this, your physician may call the Advanced Nurse Practice for the Addiction Medicine Program at 416-535-8501, X 7055 Fax: 416-425-7896 or 416 –425-9117)

_____
Signature of Referring Physician's & or Nurse Practitioner)

_____
Print Name and Credentials (Referring Physician's & or Nurse Practitioner)

*** Please also have client/patient go to pharmacy to obtain a MED CHECK and fax back with application.**

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INTAKE MEDICAL - GTA
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Client/Patient Name: _____ Health Record #: _____
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PHYSICIAN COMPLETES PART A

CLIENT/PATIENT COMPLETES PART B

Recommendations for Activity Level:

A. PHYSICIANS PLEASE COMPLETE:

Medical status for participation in Leisure in Action activities:

		Yes	No
1.	Restrictions	☐	☐

2. Client/Patient may participate in the following activities: (please tick)

Tai Chi	☐	Step Machine	☐
Yoga	☐	Weight lifting	☐
Strength -Program	☐	Stretching	☐
Exercycle	☐	Exercise: Light	☐
Basketball	☐	Moderate	☐
Walking	☐	Heavy	☐

3. Medical condition requiring attention. Please describe:

_____

_____

Physician Name: _____

Physician Signature: _____

Date: _____
(dd/mm/yyyy)

B. CLIENT PLEASE SIGN:

I have read and I understand the recommendations for participation in activities as stated above.

Client Name: _____

Client Signature: _____

Date: _____
(dd/mm/yyyy)