ESK’ETEMC

Letwilc ren Semec Centre (LRSC)

Application Form For Client

Physican or Nurse Practitioner’s Report

RESIDENT CLIENT NAME	DATE OF BIRTH

PHYSICIAN or NURSE PRACTITIONER'S REPORT

SURNAME (LEGAL)	FIRST NAME	MIDDLE NAME
CARE CARD NUMBER	**STATUS NUMBER**	

INFORMED CONSENT MUST BE COMPLETED WITH PATIENT

I, _____ (Resident Client's Name), hereby request and give permission to _____ to release my medical information to LETWILC REN SEMEC CENTRE and my referral worker.

I also consent to have the LETWILC REN SEMEC CENTRE nurse, counsellor, or treatment staff consult or inquire with my above-named health care provider regarding any of my medical needs while in treatment.

RESIDENT CLIENT SIGNATURE: _____

DATE: _____

DIABETES ☐ YES ☐ NO	ALLERGIES ☐ YES ☐ NO	
EENT:	HEARING LOSS:	IMPAIRED VISION:
RESP / ASTHMA:	S.O.B:	CHRONIC COUGH:
CVS / CHF:	ANGINA:	MURMUR:
GI / ULCERS:	REFLUX:	DYSPESIA / LIVER:
GU / FREQ UTI:	PROSTATISM:	NEURO:
SKIN	INFESTATIONS:	INFECTIONS?
MENSTRUAL LMP:	PREGNANT?	☐ YES ☐ NO
IF YES, WHAT TRIMESTER?	ANY PROBLEMATIC PREGNANCIES?	☐ YES ☐ NO
SKIN	INFESTATIONS:	INFECTIONS?
STDS?	NEG	POS
HEP C?	NEG	POS
HIV / AIDS TEST?	NEG	POS

RESIDENT CLIENT NAME	DATE OF BIRTH

PHYSICIAN or NURSE PRACTITIONER'S REPORT

(To be completed by Client's Physician or Nurse Practitioner)

IS THIS PATIENT ON ANY MEDICATIONS? ☐ YES ☐ NO PRE-ADMISSION MEDICATION LIST 14 DAYS PRIOR TO INTAKE

NAME OF MEDICATIONS	AMOUNT	FREQUENCY	REASON
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

YOUR CLIENT'S MEDICATIONS ARE REQUIRED TO BE BLISTER PACKED ON A WEEKLY BASIS. **NOTE: AFTER RECEIVING CONFIRMATION OF YOUR CLIENT'S ACCEPTANCE TO LRSC, IT IS MANDATORY THE CLIENT'S PHYSICIAN or NURSE PRACTITIONER FAXES THE ORIGINAL PRESCRIPTION(S) TO ESK'ETEMC HEALTH CENTER (FAX: 250-440-5691). NO EXCEPTIONS.**

- PLEASE LIST ADMISSION DIAGNOSIS WITH A BRIEF HISTORY OF PRESENT ACTIVE MEDICAL CONDITIONS.
- PROVISIONS FOR ANY FOLLOW-UP TREATMENTS OR CARE REQUIRED WHILE IN TREATMENT AT LRSC? PLEASE SPECIFY.
- ANY PERTINENT PHYSICAL EXAMINATION FINDINGS? PLEASE SPECIFY.

RESIDENT CLIENT NAME	DATE OF BIRTH

PHYSICIAN or NURSE PRACTITIONER'S REPORT

(To be completed by Client's Physician or Nurse Practitioner)

IS PATIENT DUAL DIAGNOSIS? FOR EXAMPLE, BIPOLAR, PTSD, SCHIZOPHRENIA, FASD, ADHD ☐ YES ☐ NO

- LENGTH OF MENTAL STABILITY? CURRENT COGNITIVE STATUS?
- ABILITY TO PARTICIPATE IN GROUP THERAPY FOR EIGHT HOURS A DAY?
- WHO PROVIDED THE DIAGNOSIS AND IS CLIENT PRESENTLY IN TREATMENT WITH THIS DOCTOR/PSYCHOLOGIST? PLEASE PROVIDE A WRITTEN SUMMARY OF CLIENT'S THERAPY PLAN.
- IS THE DIAGNOSING DOCTOR IN AGREEMENT WITH A/D TREATMENT?

_____

_____

_____

_____

AS A PRE-REQUISITE TO RESIDENTIAL POST RECOVERY SUPPORT SERVICES, THE PATIENT MUST:

- BE FREE FROM ALL COMMUNICABLE DISEASES (I.E. SCABIES, LICE) ☐ YES ☐ NO
- HAVE A TB TEST IN THE LAST 12 MONTHS (ATTACH RESULTS) ☐ POS ☐ NEG ☐ DATE:_____

NOTE: IF TB SKIN TEST IS POSITIVE AND RESULTS MEASURE LARGER THAN 10mm, SKIN TEST RESULTS MUST BE FOLLOWED UP BY TB CHEST X-RAY.

- HAVE COMPLETED STAGE II TREATMENT DEFINED AS: INDIVIDUALS WHO HAVE COMPLETED SOME TYPE OF RECOVERY BASED
- PROGRAM AND ARE STABILIZED

PHYSICIAN / NURSE PRACTITIONER NAME ADDRESS CITY PROVINCE POSTAL CODE TELEPHONE FAX	**OFFICE STAMP**
PHYSICIAN / NURSE PRACTITIONER SIGNATURE	**DATE**

Note: Please ensure you have read and reviewed PART 8 – Safe/Unsafe Medications List – Updated: July 4, 2016 on page 13, as non-compliance with said list will result in the Resident Client not being accepted.

RESIDENT CLIENT NAME	DATE OF BIRTH

SAFE / UNSAFE MEDICATION LIST

PHYSICIAN'S REPORT

The following list is for common and prescription medications, which are Safe / Unsafe for use for persons in recovery. If a medication changes the way you feel or is mood altering, AVOID IT.

NOTE: Ensure generic medications fall into the Safe category of acceptable medications.

UNSAFE	SAFE
Avoid pain medications that contain Opiates (e.g. Codeine): • Tylenol 1, 2, 3 or 4 (all Opioids) • Demerol • Percocet • Fiorinal Plan 1⁄4 or 1⁄2 • Levo-Dromoran • 222, 282, 292, 692, Darvon (Propoxyphene) • Talwin • Percodan • Leritine • Dilaudid • Nabilone **Avoid Nerve and Sleeping Pills including:** • Librium • Tranxene • Serax • Xanax • Others used for anxiety/nervousness/ tranquilizer • All Benzodiazepines **Avoid CNS Stimulants such as Methamphetamines:** • Dextroamphetamine (Dexedrine) • Lisdexamphetamine **Avoid Sleeping Pills including these and others:** • Dalmane • Halcion • Restoril • Tuinal • Seconal • Zopiclone (Imovane) **Avoid Muscle Relaxants:** • Robaxisal • Robaxacet • Parafon • Flexeril **Over the Counter Medications can be a Serious Threat:** • Cough syrups contain alcohol, codeine and antihistamines. These are all drugs which need to be avoided. **Avoid Sedating Antihistamines such as:** • Gravol/Actifed • Dimetap • Chlortriplon • Benydryl or products containing diphenhydramine	**Pain Medications:** • Regular or Extra Strength Tylenol • ASA or Aspirin • Advil or Ibuprofen • Midol **Available Only by Prescription:** • Tryptan • Buspirone (Buspar) • Gabapentin • Toradol • Possible other prescription medications – please contact Resident Nurse for clarification **Antidepressants Safe by Prescription Only:** • Elavil • Citalopram • Morex • Serzone • Desipramine • Effexor (Venlafaxine) • Zoloft (Sertraline) • Prozac (Fluoxetine) • Luvox (Fluvoxamine) • Paxil (Paroxetine) • Trazodone (Desyrel) • Mirtazapine • Buproprion • Seroquel (Quetiapine) **Migraines:** • Imitrex **Non-Sedating Antihistamines:** • Seldane • Claritin • Hismanil **Sleep Aids:** • Epsom Salt • Melatonin • Calcium (333mg) Magnesium (167mg) with VD3 • (5mcg) • Lavender Oil

Note: This is a partial list. If you require more information, please ask the Doctor or Pharmacist about non-psycho active/mood-altering medications.result in the Resident Client not being accepted.

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METHADONE HARM REDUCTION TREATMENT

PHYSICIAN'S REPORT

To refer an applicant on methadone to the Methadone Maintenance Program at LRSC, you must contact the Intake Coordinator to ensure your client meets the following requirements.

1. The applicant requirements include: A history of having been stabilized on methadone for 4 weeks within a daily therapeutic dose of 60mg-100mg, not to exceed 170mg. This means the dosage of methadone has not been in the process of upward titration in the last 4 weeks.
- Stabilization would be when a person is not experiencing withdrawal symptoms or cravings (occurs when under medicated) or drowsiness (nodding) or constriction of pupils (occurs when over medicated).
- Be abstinent free for 2 weeks from alcohol, illicit drugs, medical marijuana and medications listed on our unsafe list.
- Proof of 2 clean urines prior to coming to LRSC, from your prescribing physician's office. One clean urine per week for the 2 weeks PRIOR to attending LRSC. Please fax results to LRSC at 250-440-5691, attention Resident Nurse.

2. The applicant may be required to have a methadone "carry" dose to arrive at LRSC and return to their home community, as it will be dependent on the amount of travel time, to and from LRSC in a mandatory lock box.
3. Methadone will be supplied by Kornaks & Hamm Pharmacy on Tuesday of intake and weekly until discharge.
4. Only after receiving confirmation of the applicant's admission to LRSC, it is mandatory that the applicant's methadone prescribing physician faxes the original prescription to: Esk'etemc Health (250-440-5691)
5. Prior to admission, the applicant will sign the Methadone Maintenance Program Contract with the methadone prescribing physician.
6. It is imperative that the applicant be aware of the mandatory two clean urines over two weeks prior to coming to Letwilc ren Semec Centre.
7. It is imperative that the applicant be aware of the mandatory supervised urine samples that may be requested for drug screening upon admission or if deemed necessary.
8. The applicant understands that methadone is a witnessed dose, under supported self-administration, by the resident nurse or other qualified personnel in the nurse's office. Client's methadone dosage will not be altered while in treatment.
9. Prior to admission, all applicants must have evidence that they are free of TB. (A Tuberculosis Skin Test can be done at any Public Health Unit.) Please arrange this as soon as you refer the applicant. Note: If the Tuberculosis Skin Test is positive, a chest x-ray must be arranged and results of the x-ray may take up to 6 weeks.

METHADONE MAINTENANCE PROGRAM CONTRACT

This contract shall be between _____ (Applicant) and the LETWILC REN SEMEC CENTRE.

My start date on methadone was _____ at a current therapeutic dosage of _____, meeting the 4-week stabilization required by LETWILC REN SEMEC CENTRE. This means the dosage of methadone has not been in the process of upward titration in the last 4 weeks.

My prescribing physician is Dr. _____ of _____.

Phone Number _____
Fax # _____

Please initial all boxes as acknowledgement of the contract guidelines

- I acknowledge that I come to LRSC stabilized on a methadone program.
- I acknowledge that I have two weeks abstinence from alcohol, illicit drugs, medical marijuana, and medications from the unsafe list.
- I acknowledge that I have an opioid use disorder and wish to continue my methadone program while at the LETWILC REN SEMEC CENTRE.
- I agree that while at LRSC, I will receive my methadone daily from the resident nurse or a qualified designate.
- The methadone maintenance program at LRSC is based on the Protocols from the BC Centre on Substance Use (BCCSU).
- I agree to adhere to the program guidelines as detailed to me upon orientation to the facility.
- I understand that my failure to participate in the program as outlined will result in a review of my suitability/stabilization for the treatment program.
- I agree to a supervised urine sample for drug screening as requested. I understand that failure to comply will result in termination from the program.
- I will swallow my methadone, witnessed, according to the protocols.

PHYSICIAN SIGNATURE _____ DATE _____

CLIENT SIGNATURE _____ DATE _____

We hope this is all the information you and your Resident Client require. If not, please feel free to phone the Intake Coordinator if you have any further questions.

RESIDENT CLIENT NAME	DATE OF BIRTH

SUBOXONE MAINTENANCE PROGRAM

To refer an applicant to the Suboxone Maintenance Program at LRSC, you must phone/contact the Intake Coordinator to ensure your client meets the following requirements.

1. The applicant requirements include: Stabilization would be when a person is not experiencing withdrawal symptoms or cravings (occurs when under medicated) or drowsiness (nodding) or constriction of pupils (occurs when over medicated). Be abstinent free for 2 weeks from alcohol, illicit drugs, medical marijuana and medications listed on our unsafe list.
- A history of having been stabilized on suboxone for 2 weeks; within a daily therapeutic dosage not tovexceed 24 mg.
- Stabilization would be when a person is not experiencing withdrawal symptoms or cravings (occurs whenvunder medicated) or drowsiness (nodding) or constriction of pupils (occurs when over medicated).
- Be abstinent free for 2 weeks from alcohol, illicit drugs, medical marijuana and medications listed on ourvunsafe list.
- Proof of 2 clean urines prior to coming to LRSC, from your prescribing physician's office. One clean urine pervweek for the 2 weeks prior to attending LRSC. Please fax to LRSC, (250) 440-5691 attention: resident nurse.

2. The client may be eligible to have a Suboxone "carry" dose to arrive at LRSC and return to their home community at the discretion of their prescribing physician, as it will be dependent on the amount of travel time to and from LRSC, in a mandatory lock box.
3. Suboxone will be supplied by the Nurses on Tuesday of intake, and weekly until discharge.
4. Upon receiving confirmation of the applicant's admission to LRSC, it is mandatory that the applicant's suboxone prescribing physician,
5. Prior to admission the applicant will complete and sign the Suboxone Maintenance Program Contract with the suboxone prescribing physician.
6. It is imperative that the applicant be aware of the mandatory two clean urines over two weeks prior to coming to Letwilc ren Semec Centre.
7. It is imperative that the applicant be aware of the mandatory supervised urine samples that may be requested for drug screening upon admission or if deemed necessary.
8. The applicant understands that suboxone is a witnessed dose, under supported self-administration, by the resident nurse or other qualified personnel in the nurse's office. Client's Suboxone dosage will not be altered while in treatment.
9. Prior to admission all clients must have evidence that they are free of TB. (A Tuberculosis Skin Test can be done at any Public Health Unit.) Please arrange this as soon as you refer the client. Note: If the Tuberculosis Skin Test is positive a Chest x-ray must be arranged and results of the x-ray may take up to 6 weeks.

Fax original prescription to: Esk'etemc Health in Alkali Lake, BC fax (250) 440-5691

SUBOXONE MAINTENANCE PROGRAM CONTRACT

This contract shall be between _____ (Applicant) and the LETWILC REN SEMEC CENTRE.

My start date on Suboxone was _____ at a current therapeutic dosage of _____, meeting the 2-week stabilization required by LETWILC REN SEMEC CENTRE. This means the dosage of Suboxone has not been in the process of upward titration in the last 2 weeks.

My prescribing physician is Dr. _____ of _____.

Phone Number _____
Fax # _____

Please initial all boxes as acknowledgement of the contract guidelines

- I acknowledge that I come to LRSC stabilized on a suboxone program.
- I acknowledge that I have two weeks abstinence from alcohol, illicit drugs, medical marijuana, and medications from the unsafe list.
- I acknowledge that I have an opioid use disorder and wish to continue my suboxone p r o g r a m while at the LETWILC REN SEMEC CENTRE.
- I agree that while at LRSC, I will receive my suboxone daily from the resident nurse or a qualified designate.
- I agree to adhere to the program guidelines as detailed to me upon orientation to the facility.
- I understand that my failure to participate in the program as outlined will result in a review of my suitability stabilization for the treatment program.
- I agree to a supervised urine sample for drug screening as requested. I understand that failure to comply will result in termination from the program.
- I will dissolve, sublingually, my suboxone, witnessed, as according to the protocols.

PHYSICIAN SIGNATURE _____ DATE _____

CLIENT SIGNATURE _____ DATE _____

We hope this is all the information you and your Resident Client require. If not, please feel free to phone the Intake Coordinator if you have any further questions.