BONNYVILLE INDIAN-METIS REHABILITATION CENTRE
P.O. Box 8148 Bonnyville, AB. T9N 2J4
Ph: 780-826-3328 Fax:780-826-4166

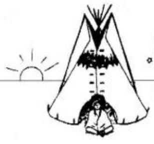
ADDICTION TREATMENT MEDICAL APPLICATION

Applications are valid for 6 months
* REFERRALS – please note any incomplete applications will result in delayed admissions date

This medical assessment is required as part of the application and must be completed in full by a medical provider.

Applicant Information			
Name:	**Date of Birth** (dd-mon-yyyy)		**Personal Health Number:**
Allergies:			
Medication Coverage Provider:		**File Number:**	
Substance Use History			
Primary	**Secondary**		**Tertiary**
	Average Amount	**Frequency (24 hrs of Use)**	**Last Use**
Alcohol			
Heroin, Fentanyl or other Non-Prescription Opioid			
Prescription Opioid			
Benzodiazepines			
Cocaine/Crack			
Methamphetamines			
Prescribed Stimulant			
Cannabis/Marijuana			
Hallucinogens			
Others:			

Review of Systems: (Please attach any relevant reports/results Ex) CBC, Urinalysis)	
EENT:	
Respiratory (Asthma, COPD)**:**	**Cardiovascular** (CVA, MI, HTN, Pacemaker)**:**
Gastrointestinal (GERD, acid reflux, pancreatitis)**:**	**Genitourinary** (Incontinence, menopause)**:**
Musculoskeletal (Chronic/acute pain, gout, RA, OA)**:**	**Integumentary** (Psoriasis, eczema, open wounds)**:**
Neurological History of seizure? ☐No ☐Yes	**Hematological** (HIV, HCV):



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Physical Examination						
Height	Weight	Temperature	Heart Rate	B/P	Resp Rate	02 Saturation

Is the patient diabetic: ☐No ☐Yes, complete this information →	Year Diagnosed:	Are they stable? ☐ No ☐ Yes

Is there cognitive impairment/delay? ☐No ☐Yes
Details:

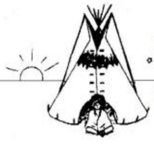
Needs assistance ambulating or providing self care/ADL's? (Uses a walker, needs shower chair, uses incontinence products). ☐No ☐Yes Details:

Pregnancy				
Is the patient pregnant? ☐ No, complete TOP boxes only → ☐ Yes, complete ALL boxes	LMP	Para	Gravida	
	EDC	Urine hCG	Prenatal Blood Work	Prenatal Ultrasound

Physician managing pregnancy and delivery	Phone	Fax

TB screening – Symptoms and History (Check all appropriate boxes):	No	Yes
Presence of a cough lasting more than 2 weeks		
Weight loss – if yes, specify: __________ lbs, in _____________ length of time		
Night sweats		
Fever		
Fatigue		
Hemoptysis (blood in sputum)		
Previous significant Mantoux or chest X-Ray results		
Extensive travel (or birth) in a country with high incidence of TB		
Other risk factors (aboriginal, elderly, homeless, health care worker)		
Poor general health status and risk factors for progress of disease		
Further TB screen/assessment required – if yes, please send results		

Medical Approval		
In your opinion, is this patient medically stable and appropriate for admission to Bonnyville Indian Metis Rehabilitation centre? ☐ No ☐ Yes		
Medical Provider Name	Signature	Date (dd-MON-yyyy)



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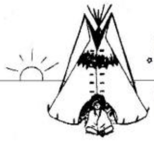
Psychiatric History/Review	**No**	**Yes**	**Comments**
Mental health conditions (depression, anxiety)			
Underlying pervasive or personality conditions (borderline)			
Acute medical conditions that are aggravating mental health (chronic pain, insomnia, cognitive impairment)			
Eating disorders (anorexia, binge eating)			
Contributing psychosocial and environmental factors			
History of self harm or suicide?			
History of psychosis?			
Have they ever been hospitalized due to mental health condition?			

Psychological Approval		
In your opinion, is this patient psychologically stable and appropriate for admission to Bonnyville Indian Metis Rehabilitation centre? ☐ **No** ☐ **Yes**		
Medical Provider Name	**Signature**	**Date** (dd-MON-yyyy)

Current Medications
***All narcotics/restricted medications require a letter from prescriber to continue medication while admitted in the program, template will be attached after medical. Please note that all restricted medication requests will be reviewed by the Executive Director to be approved.**

Medication	**Dose**	**Prescriber**	**Length of time used**

Suboxone/Sublocade	
Date Started on Suboxone/Sublocade	**Prescriber**
Current Dose	**Next Injection** (Sublocade)



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Health Care Team		
Support Type	**Name**	**Contact information**
Family Doctor		
Psychiatrist		
Addictions Counsellor		
Other: ________________________		

List any upcoming medical appointments, court dates etc. that we need to know about when scheduling your treatment date.	
Type of Appointment	**Date** (dd-Mon-yyyy) **Time** (hh:mm)

Please remind the client that in order to be admitted into Bonnyville Indian Metis Rehabilitation Centre the need to:

- Be well enough to participate in programming throughout their stay
- Be **drug and alcohol free for at least 7 days prior** to admission. If they arrive intoxicated or under the influence, their admission will be deferred till appropriate detox has been completed and another bed becomes available.
- Bring 1 week of medication (in original packaging), allowing staff to transfer medications for dispensing at the facility. Note all prescription medication will need to be covered by insurance or paid for out of pocket of the client.
- If the clients medical or psychological condition changes before their admission date, they must inform the facility.

Are you the applicant's regular physician?	**No**	**Yes**
Do you require a discharge summary?	**No**	**Yes**

Physician (Print):	**Signature:**
Mailing Address:	
Phone:	**Fax:**
Detox Nurse (Print):	**Signature:**
Detox Site:	
Date health assessment was completed:	

I herby authorize the above-named physician/detox nurse to release to the staff at the Bonnyville Indian Metis Rehabilitation Centre, medical information which is required to assess my suitability for acceptance and admittance to their residential treatment program

Applicant Signature: ____**Date:** ___________________________

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Medication Policies

- All medications are turned in upon admission reviewed by the nurse and partner pharmacy and dispensed by staff as prescribed by the doctor.
- Non-prescription medication needs to be in original packaging. Our partner pharmacy will review it against your scheduled medication and provide an order on how staff can administer the medication.
- All medications that are on the **RESTRICTED MEDICATION** list require a physician letter requesting the client remain on the medication for the duration of their stay and the appropriate diagnosis that accompanies the medication (template attached). All restricted medication requests will be reviewed on a case-by-case basis. The Executive director holds the right to review and decline any restricted medications.

Mental Health Medications permissible but not limited to:

- Olanzapine/Zyprexa
- Quetiapine/Seroquel
- Carbamazepine/Tegretol
- Flavoxamine/Luvox
- Risperidone/Resperdal
- Desvenlafaxine/Pristiq
- Amitriptyline/Elavil
- Desipramine/Norpramin
- Fluoxetine/Prozac
- Sertraline/Zoloft
- Chlorpromazine/Largacti
- Paroxetine/Paxil
- Venlafaxine/Effexor
- Desyrel/Trazodone
- Citalopram/Celexa
- Mirtazapine/Remeron

Pain medications permissible but not limited to:

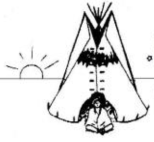
- Acetaminophen/Tylenol
- Arthrotec
- Baclofen
- Advil/Ibuprofen
- Diclofenac
- Cyclobenzaprine
- Naproxen/Aleve
- Ketorolac/Toradol
- Gabapentin

Restricted Medications *Any medication listed requires physician request to continue while admitted:

- Alprazolam/Xanax
- Flurazepam/Dalmane
- Temazepam/Restoril
- Clonazepam/Rivotril
- Chlordiazepoxide/Librium
- Concerta
- Dextroamphetamine
- Lorazepam/Ativan
- Bromazepam/Lectopam
- Triazolam/Halcion
- Nitrazepam/Mogodon
- Zoplicone/Imovane
- Vyvanse/Lisdexamfetamine
- Diazepam/Valium
- Meperidine/Demorol
- Propoxyphene/Darvon
- Dexedrine
- Adderall XR
- Ritalin

Restricted Medications that are NOT permissible even with a request from a provider.

- Tylenol 1-4
- Codeine
- Morphine
- Hydromorphone/Dilaudid
- Oxycodone (Percocet)
- Oxymorphone
- Hydrocodone/Vicodin
- Fentanyl
- Methadone



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Restricted Medication Continuation Request Form

Date: ____________________________________

I, ____(physician/provider name) request that

____(client name) continues taking the following medication(s) while admitted at the Bonnyville Indian-Metis Rehabilitation Centre. Continuing these medications will assist the client's ability to participate in the program.

Authorized medications:

Medication: ____

Diagnosis: ____

Medication: ____

Diagnosis: ____

Medication: ____

Diagnosis: ____

Medication: ____

Diagnosis: ____

Medication: ____

Diagnosis: ____

Physician/Provider Signature: ____ **Date:** ___________________________