SECTION M – MEDICAL QUESTIONNAIRE AND PRESCRIPTION FORM

To Be Completed by a Physician or Nurse Practitioner

Dear Doctor or Nurse Practitioner,

Your patient has applied to attend Bridgeway's Intensive Adult Treatment Program. Bridgeway is not a medical facility, so individuals must be medically stable upon arrival. This may mean that a person may require medical detox or medication stabilization prior to attending this program. Upon arrival participants are expected to engage fully in all programming including group therapy, psychoeducation workshops and individual counselling.

Please type out all orders that your client requires to facilitate admission to our 42-day program. We require participants to attend program with a 42-day supply or have a script sent directly to our pharmacy before their admission. Pharmacy details are below.

Patient Information

First Name:	Last Name:
Personal Health Number:	Patient Phone Number:
Date of Birth (YYYY/MM/DD):	Province:
Height:	Weight:
Drug Allergies:	
Food Allergies:	

Medication

Please check all categories representing types of prescription medication that are currently being used:

☐ Anti-depressants ☐ Anti-anxiety ☐ Anti-psychotic ☐ Pain medication

☐ Other (specify): _____

_____

Medication Assisted Treatment

Date initiated Methadose program:	Current dose: _____ ml.
Date initiated Suboxone program:	Current dose: _____ mg.
Length of time on current dose:	

Medication Orders for Participants 42 day stay at Bridgeway

Medication (Prescribed & Over the Counter)	Instructions for use and quantity	**Orders authorized for 42 days unless otherwise specified**

Prescribing Physician's Name:	Prescribing Physician's Phone Number:

Current medications if different from medication orders for during Treatment		
Medication	Purpose	Date of last dose

Is your patient stable on their current medication? ☐ Yes ☐ No

If no, please provide a date you anticipate they would be stable?

If yes, for how long have they been stable on their medication?

Symptoms/ Conditions/ Diagnoses:

Seizure History

Has your patient suffered seizures in the past year: ☐ Yes ☐ No

If yes, were the seizures related to withdrawal: ☐ Yes ☐ No

If not withdrawal related, please describe: *(e.g. the cause, frequency, how they are managed etc.)*

PHARMACY INFORMATION

Gray Road	Ethel Street (female applicants)
Two Nice Guys Pharmacy: **Phone:** (778) 753-6897 **Fax:** (778) 753-6903 **Email:** info@twoniceguyspharmacy.ca	**Juniper Pharmacy:** **Phone:** (250) 762-7306 **Fax:** (250) 762-7193 **Email:** info@juniperrx.ca

PHYSICIAN SIGNATURE

Your patient is medically and physically able to participate in an intensive facility-based treatment program for substance use: ☐ Yes ☐ No

Physician or Nurse Practitioner Name:	Telephone Number:
License Number:	Fax Number:
Physician or Nurse Practitioner Signature	
Date	

SECTION M ADDENDUM – PREGNANCY INFORMATION

Pregnant: ☐ Yes ☐ No ☐ Unknown	Anticipated Due Date:
Last Menstrual Period:	Number of Weeks Pregnant: ☐ Confirmed ☐ Assumed
Health conditions related to pregnancy:	

Substance Use During Pregnancy

Substance	Route	Frequency (days per month)	Amount	Date of last use	Is the use ongoing
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Medication Assisted Treatment: ☐ Suboxone ☐ Methadone ☐ Kadian ☐ Hydromorphone ☐ Safe Supply

Is this applicant stable on this MAT medication: ☐ Yes ☐ No

Professional Pre/Post Natal Supports

Name	Profession	Contact number	Email	Consent to Release information

Please provide information on prenatal care provided:

Upcoming prenatal appointments:

Please provide information on the applicant's birth plan:

Please provide any additional information that would be helpful to know about the applicant's pregnancy:

PHYSICIAN SIGNATURE

Physician or Nurse Practitioner Name:	Telephone Number:
License Number:	Fax Number:
Physician or Nurse Practitioner Signature	
Date	