

# Youth Recovery House Withdrawal Management Referral

Email: [info@thebridgeservices.ca](mailto:info@thebridgeservices.ca) Phone: (250) 763-0456 ext. 2503 Fax : (250) 717-6395

**Referrer Details:**

Date: \_\_\_\_\_  
 Referring Person Name: \_\_\_\_\_  
 Organization/office: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

**COVID – 19 Screening:**

- Fever >38
- Cough – New or Increased
- Recent Travel outside of Country
- Exposed to known infected person
- CPAP Machine
- COVID/ Isolation info Explained

**Individual / family details**

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Participant Phone: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Contact Information: \_\_\_\_\_

**MCFD Legal Status:** (if Applicable) \_\_\_\_\_

**Other Professionals Involved:**

Primary Service Provider & Role: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name & Role: \_\_\_\_\_ Phone: \_\_\_\_\_

**In an emergency contact:**

Name	Home Telephone	Work Telephone	Cell Phone
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**Care Card #** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Medications/special diet:** \_\_\_\_\_

**Medical concerns/diagnosis:** \_\_\_\_\_

**Dr. Diagnosed or Suspected Mental Health/ Self-Harm/ Suicide attempts/ Brain Injury:**

<b>ALCOHOL:</b>	<b>GHB?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>STIMULANTS:</b>	<b>OPIATES:</b>
Daily? Yes <input type="checkbox"/> No <input type="checkbox"/> How much per day/week?		Regular Use? How Much per day?	Regular Use? How much Per day?
Mouthwash or Solvents?		Injects?	Injects?
History of Seizures or DT's?		Chest Pain with Use?	Hx of OD? Narcan?
			Hx of Severe W/D?
			Interested in OATS? Dr. Support on D/C?

**Participants referred to YRH Withdrawal Management MUST have a confirmed Transition Exit Plan prior to admission.**