Return Completed Form with Cover to:
Chinook Regional Hospital
960 19 St S, Lethbridge, AB T1J 1W5
LETHBRIDGE RECOVERY CENTRE
Phone: 403 388 6243
FAX: 403 388 6528

REFERRAL COVER

Medically-Supported Detoxification Program Goals

- The goal of this two-phase program is to provide safe and effective medically-supported detox to adults (age 18 or above) with substance use disorders, with the opportunity to participate in programming in preparation for treatment and ongoing recovery. This will generally require between 7 and 10 days of care on our unit.
- The program is grounded in evidence-based concepts of recovery, trauma informed care, person-centered approaches, culturally safe care, and harm reduction.

Indications for Detoxification

- We provide detoxification services to people that consume and have moderate to severe dependence on substances.
- We provide Suboxone Initiation services for those who would benefit from inpatient Suboxone initiation.

Care Recommendations for Completion before Admission

☐ Pre detoxification goal setting – in addition to the goal of medically-supported detoxification, please identify specific goals related to next steps for support upon discharge. This will allow staff to plan and develop individualized care plans while in detoxification.

☐ This is a 7-10 day program and it is important to account for any social needs that may come up during that time (i.e. excused from work, child care, pet care).

☐ This is a tobacco-free program. While nicotine replacement therapy will be provided, it is important to realize before arriving that the individual will be unable to use tobacco products while admitted, counselling and smoking cessation planning is important to promote completion of detoxification.

☐ Bring only enough clothing for the duration of stay. Excess belongings are not required, will not be accessible during detoxification, and with limited storage we cannot guarantee safe storage at the program.

☐ It is not required to stop using your substance prior to arriving for admission. Please arrive in a state where you are capable to understand and complete paperwork.

☐ Please do not bring any illegal/illicit substances/items, alcohol or cannabis into the program – these items will be discarded upon arrival.

☐ It is essential that pre and post detoxification planning occurs. This planning should include conversations about what to do in the days leading up to detoxification admission and the care that will occur in the weeks following discharge.

Expectations upon Arrival to the Program

During the client's stay in the Lethbridge Recovery Centre they will receive medical and psychosocial care throughout their stay. As they begin to recover medically they will receive therapeutic counselling in the form of individual and group sessions. We will work with the individual and their community supports to bridge to a successful discharge plan as their detoxification completes.

Prioritization

☐ Is this client pregnant? Any client that is intending to detox and is *pregnant* will be prioritized.

☐ Is this client geriatric? Any client that is intending to detox and is *geriatric* will be prioritized.

☐ Does this client have a treatment date? Any client who needs to go door-to-door from detox to treatment will be prioritized.

Thank you for your Referral - you will be contacted (both client and referral source) regarding the outcome of this referral.

Alberta Health Services

LETHBRIDGE RECOVERY CENTRE REFERRAL FORM

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This form is best completed with the client to ensure accuracy of the information. The goal of the Centre is to provide safe and effective medically-supported detoxification within a period of 7-10 days. Client preparedness and aftercare plans will improve the outcome of the detoxification.

1) CLIENT INFORMATION

Client Name		Phone #	Message okay? ☐
Date of Birth	dd/mm/yyyy	City/Town	
Address			
Postal Code		Province	Alberta
Email		Health Care Number	
ASIST Number if Available			
Person to Notify		Phone #	Message okay? ☐
Legal Guardian		Phone #	Message okay? ☐

2) REFERRER INFORMATION

Referrer Name			
Referrer Address			
Referrer Phone Number	Message okay? ☐	Referrer Fax Number	
Relationship		Will you be providing ongoing support?	Yes ☐ No ☐

3) PHYSICIAN INFORMATION

If client does not currently have a Primary or Family Physician please support the individual in seeking one while waiting for the Lethbridge Recovery Centre.

Primary Physician Name (If available)		Physician Clinic	
Physician Phone Number (If available)		Physician Fax Number (If available)	

4) OTHER AGENCIES, SUPPORTS OR INDIVIDUALS INVOLVED

Name	Phone Number	Organization	Last Seen	Upcoming Appts/Intake
			dd/mm/yyyy	
			dd/mm/yyyy	
			dd/mm/yyyy	

5) INDICATIONS FOR REFERRAL

Alcohol Use Disorder

- ☐ Regular Alcohol consumption of greater than 10 Drinks/day
- ☐ History of epilepsy
- ☐ History of withdrawal-related seizures
- ☐ History of delirium tremens/ confusion/ hallucinations
- ☐ Concurrent withdrawal from alcohol and benzodiazepines

Opioid Use Disorder

Suboxone Induction Criteria:

- ☐ Polysubstance use including Opiate Use
- ☐ Vulnerable social situation
- ☐ Homeless
- ☐ Unstable housing
- ☐ At risk housing
- ☐ Unstable connections to supports
- ☐ Few or no supports
- ☐ Complex health needs
- ☐ Complex physical health needs *(specify below)*
- ☐ Complex mental health needs *(specify below)*
- ☐ Complex cognitive needs *(specify below)*
- ☐ Not able to abstain long enough to initiate Suboxone in the community
- ☐ Has been assessed as benefiting from Inpatient Suboxone Initiation *(specify below)*

Other Indications

- ☐ Polysubstance dependence
- ☐ Seniors (≥ 65 years)
- ☐ Significant psychiatric or physical comorbidities *(specify below)*
- ☐ A significant intellectual/developmental disability or cognitive impairment *(specify below)*
- ☐ Homeless or no social support. Home environment unsupportive of abstinence
- ☐ History of failed community detoxification
- ☐ Pregnancy
- ☐ Significant risks *(specify below)*
- ☐ Stimulant Use Disorder
- ☐ Withdrawal Symptoms – i.e. Sleep Disturbance, Anxiety, Mild Psychotic Symptoms

Medically Supported Detoxification is not indicated for Cannabis Use Disorder or Tobacco Use Disorder.

Please note: *Per the* Canadian Low-Risk Alcohol Drinking Guidelines *a drink is defined as 341ml/12oz of 5%* **Beer**, *341ml/12oz of 5%* **Cider/Cooler**, *142ml/5oz of 12%* **Wine**, *or 43ml/1.5oz of 40%* **Distilled Alcohol**.

Comments:

☐ **Willing to initiate Suboxone (if applicable)**

6) CURRENT SUBSTANCE USE PATTERN (In the past month)

Please describe the client's pattern of substance use including the type/amount/frequency of use/route of administration (e.g. drink, smoke, snort, inhale, inject, etc) and **date of last use**

Type	Amount	Frequency of Use	Route	Date of Last Use
				dd/mm/yyyy
				dd/mm/yyyy
				dd/mm/yyyy
				dd/mm/yyyy

For additional space please attach a summary note as required. ☐ *Please see attached*

7) PREVIOUS DETOXIFICATIONS (If Known)

Have you completed Medical Detoxification in the past 4 months?	Yes ☐ No ☐

If yes, please describe what plans you have in place to make this Detoxification different to increase your chance for recovery:

8) CURRENT/PAST MEDICAL HISTORY (Include diagnoses)

Current Pregnancy Yes ☐ No ☐ Unknown ☐

☐ HIV Positive

☐ Hepatitis C Positive

☐ History of Liver Impairment

Most Recent Hospitalization:

Date_____ Concerns_____

Date and Results of Last Labs (if known)

Date_____ Concerns_____

9) SOCIAL CIRCUMSTANCES

☐ Employed ☐ Unemployed ☐ Homeless ☐ Lives Alone

☐ Lives with Partner ☐ Lives with Friends/Family ☐ Shelter ☐ Hotel

Number of Dependents/ Children	
Ages	
Source of Income	
Medication Coverage	

10) UPCOMING APPOINTMENTS

Upcoming Court Dates:

Other (Describe):

Comments:

11) POST DETOXIFICATION PLAN

Describe:

Are you interested in attending treatment door-to-door after detox?	Yes ☐ No ☐

If yes, please make arrangements to attend treatment following detox to facilitate a timely access to treatment.

Please indicate your treatment program date if you have one:	

If you have a treatment program date, we will plan to admit you within 10 days of your treatment program date, to ensure a successful door-to-door transition.

12) ANY OTHER RELEVANT INFORMATION

Are you on OAT (Methadone, Suboxone, Kadian, Sublocade, etc.)?

13) SIGNATURE

I confirm that the client/guardian is aware of this referral

Referral Source		**Client/Guardian (if possible)**	
Name		Name	
Signature		Signature	
Referral Date		Referral Date	