

Client Name:	SUBSTANCE USE WITHDRAWAL MANAGEMENT AND RECOVERY TEAM
DOB:	Gender:
Phone:	Address:
PHN:	

Clinician Name:	Location:
Address:	
Admission Date:	Discharge Date:
<input type="checkbox"/> Planned Discharge <input type="checkbox"/> Transfer to hospital <input type="checkbox"/> Patient initiated discharge	

Discharge Substance Use Care Medications, Dosage and Instructions

Comments:

Complications presented during Treatment Course

Delirium
 Overdose
 Psychosis
 Seizure

Comments:

Medical Follow up/Discharge Destination

Medical/OAT post-discharge destination: <input type="checkbox"/> Primary Care or GP Clinic: Name: <input type="checkbox"/> RAAC <input type="checkbox"/> New Referral <input type="checkbox"/> Return for Follow-up <input type="checkbox"/> Substance-Use Team Name: <input type="checkbox"/> Other Name:	<input type="checkbox"/> SU Bed Based Treatment/Support Recovery/Transitional destination: Name: Outpatient/community Services (if applicable): <input type="checkbox"/> Overdose Outreach team <input type="checkbox"/> Daytox <input type="checkbox"/> SU Counselling Team:
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Harm Reduction Plan

THN
 Risk Mitigation Prescription
 Harm-reduction Education

Comments

Physician Name:	Physician Signature:	
Date:		

Client Name:

DOB:

Gender:

PHN:

Phone:

Address:

**SUBSTANCE USE WITHDRAWAL
MANAGEMENT AND RECOVERY TEAM**

Treatment Plan

Alcohol

High Risk for Alcohol WD complications PPC Low Risk for Alcohol WD complications PPO Objective Alcohol WD PPO

Opioids

Opioid Agonist Therapy Titration Kadian Titration Methadone Titration Suboxone Microinduction Suboxone Transition
 Suboxone Standard Induction Sublocade Fentanyl Patch Titration
 Declined Opioid Agonist therapy PRN opioids only Opioid Agonist Therapy Stable

Stimulants

Continue Risk Mitigation Medication

Nicotine

Ongoing Care Medications Nicotine Replacement Therapy

Cannabis Use

Benzodiazepine or other Sedative-Hypnotic Use

Benzodiazepine WD due to unintentional use (CIWA and/or taper) Benzodiazepine withdrawal due to intentional use taper

Substance Use Disorder (Other)

Ongoing Care Plan

Physician Name:

Physician Signature:

Date: