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MRTC JOURNEY TO WELLNESS

Referral / Admission Guidelines

1. The referral source completes the Referral form. Examples of a referral source are; Physician, Substance use Counsellor, Concurrent Disorder Therapist, EAP Worker, Psychiatrist, Parole/Probation Officer. Self referrals are NOT accepted. A Physician must complete the Pre-Admission Medical Evaluation and the applicant's Financial Aid Worker needs to complete the funding confirmation form if applicable. Please provide MRTC with the complete background information necessary to ensure an effective residential treatment experience for the client. **Referrals from Health Authorities and their contractors must submit the current GAIN-SS (Included on pages 9-10) and HoNOS scores (not included).** Please have your client contact the MRTC admissions department 2-3 business days after submitting the referral to discuss the next steps.

2. **A Tuberculosis test should have been performed within the last year**. The original TB form can be faxed to our office directly, or brought with the client on his admission date. TB tests are considered valid for 1 year and should not expire while @ MRTC. If you are unable to get a TB test done in your community, or if you are experiencing delays in getting your testing done, please contact our admissions department and we can help arrange to have this test done once you are admitted in the program.

3. **Medical Stabilization –** Intensive residential treatment requires physical and mental readiness. If your patient has faced recent challenges with physical or mental health concerns, we may require confirmation that he is stable, on any necessary medication and is receiving appropriate treatment as we are not a medical facility. We require a **minimum of 7 days free** from any illicit/non-prescribed mood altering substances. Clients will be **urine screened/breathalyzed upon arrival**, and admission may be refused based on results.

4. **Methadose/Suboxone Applicants -** Clients on Opioid Replacement Therapy must be stable on their current dose for at least one month before entering treatment. Clients weaning off ORT are eligible to enter treatment 14 days after their last ORT dose. All clients are required to bring with them a written 5-week prescription for their medication and turn it in to medical staff on arrival. A faxed copy needs to submitted to MRTC a minimum of 2 days prior to admission and be for 35 days in length.
   All ORT clients are to be prescreened by medical staff prior to admission. Medical admission information should include 'Urine flow sheets", and ECG for clients on a dose of 10mls of Methadose or greater. Clients on ORT will be screened for contra indicated medications such as benzodiazepines. All ORT clients will be expected to follow the guidelines of the College of Physicians and Surgeons ORT program standards. Clients are expected to provide a witnessed urine drug screen upon admission for baseline purposes and will be subject to random screens.

5. We encourage you to **review the Program Description** that can be found online (www.mrtc.bc.ca) and discuss the treatment program with the client. In our experience, a well-prepared and well-informed client is much more likely to complete the intensive residential treatment program and seek follow-up after discharge. It is particularly important that clients understand that our program is primarily group therapy. Comprehensive information on our program including the program description is available on our web site or by contacting our admissions department.

6. Please tell your client **not to fill the attached prescription**. NOTE – We are required to collect any medications brought from home and will retain and return them upon discharge (except for Narcotic based medications). A supply of all approved medications will be ordered as prescribed when the client is admitted and will be administered on site by MRTC staff. A 7 day supply of all medications will be provided to the client at the end of their stay. Please ensure your client brings with them any 3rd party insurance coverage information with them. No vitamin, herbal or workout supplements are permitted on site without a prescription by the clients' physician.

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MRTC
JOURNEY TO WELLNESS

Referral for Admission

Referral Date:______________________________
DD MM YYYY

Please complete this form with your client/patient

Client Information:

Name: ____________________________ , ________________ ________________________________
Surname Middle First

Prefers to be called: ________________________________

Date of Birth: ______________________________ Age: ____________
DD MM YYYY

Address: ____
Apt # Street City PC

Home Phone: ______________________________ Mobile/Alternative: ______________________________

Ok to speak to another member of household? ☐ Yes ☐ No Okay to Leave Message? ☐ Yes ☐ No

Marital Status: _____________________________ F.H. PARIS ID# (if known): _______________________

PHN# (Care Card): _______________________________________

Emergency Contact Name: ____
Relationship: ____
Contact Numbers: (___) ___________________ Alternate: (___) ______________________________

Referral Source Information:

Referral Source Name: ____
Position: ___________________________________ Agency: ______________________________________
Address: ____
Unit # Street City PC

Phone Number: (___) ______________________________ Fax: (___) ______________________________
E-mail: ____
Length of time working with this client: ____

Payment Information:

Funding needs to be in place and confirmed prior to an admission date being booked.

☐ **Self Payment**:

Fee payable **upon admission** by Cash, Cheque, Debit, Amex, Master Card or Visa. Please contact MRTC for the current fee.

☐ **Employer/Other**:

Employer will be invoiced upon admission. If possible, please include approval letter from employer. Due to the variety of ways insurance companies can approve/cover/pay for treatment fee's, we strongly suggest getting any approval in writing.

Contact Name: ____________________

Company Name/Agency: ____________________

Phone: (___)____________________Fax: (___)____________________

Mailing Address:

____

Unit # Address

____

City Prov. PC

☐ **Mental Health and Addictions Services:**

Attach Accommodation Fee Subsidy Request Approval or provide date funding has been requested. ____________________

☐ **Ministry of Social Development:**

Please have your Worker/office complete the form on the next page and fax to MRTC: 604-466-6988. You need to discuss with your worker/office any travel costs associated with attending treatment and/or continuation of your current housing shelter costs. Your home office will retain control of your file as MRTC and the Maple Ridge MSDSI office do NOT have liaisons so all questions need to be directed to your home office.

Prescription Coverage through Extended Benefits:

If you are covered under extended benefits, please include a copy of both sides of card with this referral.

Ministry of
Social Development
and Social Innovation

CONFIRMATION OF INCOME

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The information will be used for eligibility purposes. The collection, use and disclosure of personal information are subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Questions regarding the collection, use, and disclosure of personal information can be directed to an Employment and Assistance Worker by phone at 1-866-866-0800.

Service Provider Name	Fax Number
Maple Ridge Treatment Centre (Fraser Health Authority) SR 1-789481282	604-466-6988
Address 22269 Callaghan Ave, Maple Ridge, BC V2X 2E2 (Phone 604-467-3471)	

Clients receiving assistance from the Ministry of Social Development and Social Innovation must inform the Ministry of their request to enter residential care/treatment prior to funding. The Ministry will process applications for funding once notified of the client's arrival on the date of admittance by the facility faxing the HR3319 to the Ministry of Social Development and Social Innovation.

Client Full Name		GA # ___________________
Phone Number	Date of Birth	SIN Number

I hereby authorize the staff from the Ministry of Social Development and Social Innovation to release information from my file required to establish eligibility for funding. This includes any income received or pending, and any missing documents that might affect my eligibility.

Client Signature ______________________ Date Signed ______________________

To be completed by ministry staff

Does the client have an open file? ◯ Yes ◯ No

Is the client receiving any other income? ◯ Yes ◯ No

Source of income ______________________

Amount of income ______________________

Is the client pending any other income? ◯ Yes ◯ No

Source of pending income ______________________

Notes

Amount to be paid to MRTC: $ ______________________

Ministry Staff Signature ______________________ Date Signed ______________________

*Be advised information is accurate as declared to the Ministry as of the date signed.

Please ensure you discuss with client how his support / shelter payments may be affected by entering this or any treatment program.

1) Peer Support/Marital Support/Family Support

Describe social support network: ____

____

____

2) Longest period of Abstinence?:

____When?______________________

3) Mental Health Information:

History of: Self Harm ☐ Yes ☐ No Suicidal Ideation ☐ Yes ☐ No Aggression ☐ Yes ☐ No

Mental Health Diagnoses: ____

Dates / Details: ____

____

Psychiatric Hospitalizations ☐ Yes ☐ No

Dates & Places: ____

____

If you answer Yes to any of the above in the previous 12 months, please provide recent psychiatric evaluation, progress notes and current treatment plan - *failure to supply these will delay processing of the referral.*

Primary Mental Health Worker / Psychiatrist : ____________________________________

Agency: ____

Phone: ______________________Fax: ______________________________________

Please list other mental health team, concurrent disorder therapist, or psychiatrists: ____________

____

4) Treatment History Information: N/A ☐

Name of Agency and dates:

Residential Treatment: ____

Detox: ____

Outpatient Counselling:____

Day Treatment: ____

Supportive Recovery/Transition House: ___________________________________

Re-admission to MRTC? ☐ Yes ☐ No If yes, previous admission date(s): ______________

5) Legal History/Status: N/A ☐

Clients **may not attend** court dates or probation appointments while at MRTC. A copy of your clients Probation/Bail conditions needs to be submitted prior to entry into the program. Please indicate if your client currently has any of the following legal circumstances:

☐ Parole, ☐ Probation, ☐ Bail or ☐ Charges Pending - For: ______________________________

____

Probation Officer or Bail Supervisor / Office: ______________________________

Phone: (   ) ______________________ Fax: (   ) ______________________

Upcoming court dates: ______________________________________

Has your client ever been convicted of any violent crime? ☐ Yes ☐ No

If yes, please provide dates and details: ______________________________

Other prior convictions: ______________________________________

Has your client ever served Federal time ☐ Yes ☐ No If yes, has he reached warrant expiry? ☐ Yes ☐ No

6) Substance Use Information:

In the previous 12 months, has your client had any incidences of overdose? ☐ Yes ☐ No

Have any required hospitalization? ☐ Yes ☐ No please provide dates: ______________________

Substance	Primary Substance Identified	Date of Last Use	Typical amount	Frequency Last 30 days	Age of First use	Does client consider substance a problem?
Alcohol						
Tobacco						
Marijuana						
Hallucinogens						
Ecstasy						
Cocaine						
Crack Cocaine						
Heroin						
Other Opiates (excluding Fentanyl)						
Fentanyl						
Illicit Methadone						
Benzodiazepines						
Meth / Crystal Meth						
Inhalants						
Ketamine						
Over the Counter Drugs(excluding codeine)						
Prescription Drugs(excluding opiates)						
Other Substances						

7) Aftercare

Does your client have safe accommodation after treatment? ☐ Yes ☐ No

Please explain: ____

____

If your client is from out of town, please ensure he has transportation / funding arranged to return home.

Who will provide follow-up counselling?

☐ Please check here if it is the same person / agency as on page one.

Name: ( ) ____________________ Agency: ( ) ____________________

Phone: ( ) ____________________ Fax: ( ) ____________________

8) Additional Comments:

____

____

____

____

MRTC provides a Discharge Summary for clients that have participated in our program.
If a Discharge Summary is requested, please indicate to whom and where you would like it faxed.

☐ Please check here if it is to same person / agency as on page one.

Name: ____________________ Agency: ____________________

Fax: ( ) ____________________ Phone: ( ) ____________________

I, ______________________________, consent for Maple Ridge Treatment Centre to receive, release and exchange information with any and all persons / agencies listed on this referral.

Signature: ______________________________ Date: ____________________

Client Signature DD MM YYYY

I, ______________________________, have reviewed the provided information and am supportive of this referral and believe this client to be an appropriate fit for MRTC.

Signature: ______________________________ Date: ____________________

Referral Signature DD MM YYYY

✷ **Note: If the above client and referral signatures are missing, this referral will not be processed**

BRITISH COLUMBIA | Ministry of Health

APPENDIX 1

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial computerized pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Scheduling Act*, S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, ______________________ (Name of Patient (print)), authorize Dr. MRTC Attending Physician (Name of Physician (print))

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

Executed at Maple Ridge, this ______ day of ______________, 20 ____.

SIGNED AND DELIVERED by

____
Patient (print)

in the presence of:

____
Witness (signature)

____
Witness (print)

____
(dated)

____
Patient (signature)

GAIN-Short Screener (GAIN-SS)
Version [GVER]: GAIN-SS 2.0.2

What is your name? a.________________________ b._____c. __________________________
(First name) (M.I.) (Last name)

What is today's date (MM/DD/YYYY) ______/_______/_______

The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more week, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "1-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	1 to 12 months ago	1 + years ago	Never
	3	2	1	0

1. When was the last time that you had significant problems…

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	3	2	1	0
b. with sleeping, such as bad dreams, sleeping restlessly, or falling asleep during the day?	3	2	1	0
c. with feeling very anxious, nervous, tense, fearful, scared, panicked, or like something bad was going to happen?	3	2	1	0
d. with becoming very distressed and upset when something reminded you of the past?	3	2	1	0
e. with thinking about ending you life or committing suicide?	3	2	1	0

2. When was the last time that you did the following things two or more times?

a. Lied or conned to get things you wanted or to avoid having to do something?	3	2	1	0
b. Had a hard time paying attention at school, work, or home?	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home?	3	2	1	0
d. Were a bully or threatened other people?	3	2	1	0
e. Started fights with other people?	3	2	1	0

3. When was the last time that …

a. you used alcohol or drugs weekly?	3	2	1	0
b. you spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs?	3	2	1	0
c. you kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	3	2	1	0
d. your use of alcohol or drugs caused you to give up, reduce problems at important activities at work, school, home, or social events?	3	2	1	0
d. you had withdrawal problems from alcohol or drugs like shaking hands, throwing up having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems?	3	2	1	0

After each of the following questions, please tell us the last time you had the problem, if ever, by answering, "In the past month" (3), "1-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	1 to 12 months ago	1 + years ago	Never
	3	2	1	0

4. When was the last time that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?..........	3	2	1	0
b. took something from a store without paying?..........	3	2	1	0
c. sold, distributed, or helped to make illegal drugs..........	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?..........	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?..........	3	2	1	0

5. Do you have other significant psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below) — Yes 1 — No 0

v1.____

v2.____

v3.____

6. What is your gender? (If other please describe below)…1-Male 2-Female 99-Other
7.
v1.____

7. How old are you today? I__I__I years

For Staff Use Only

8.Site ID:__________________________Site Name v. ________________________
9.Site ID:__________________________Staff Name v.________________________
10. Client ID:_______________________Comment v. _________________________
11. Mode: 1) Administered by staff 2) Administered by other 3) Self-administered
12. Number of 2's and 3's: IDSscer: ____EDScr: _____ SDScer: _______ CVScr:______ TDScr:____
13. Referral: MH___ SA_____ ANG______ Other ______ 14. Referral Code: ________
15. Referral comments:

v1: ____
v2: ____
v3. ____

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MRTC JOURNEY TO WELLNESS

Pre-admission Checklist – Please give to your Client/Patient

Maple Ridge Treatment Centre is located at 22269 Callaghan Ave, Maple Ridge. The nearest major intersection is Lougheed Hwy and 222nd Ave. We are one block south on 222nd.

Your admission appointment, as discussed with the admissions staff, is a date and time that has been reserved for your arrival. If you are unable to arrive at your scheduled admission time, you should contact the MRTC prior to your scheduled intake date to make other arrangements. If you miss your scheduled appointment time, there is a chance that our staff may not be able to process your admission and will need to rebook your appointment.

If you are travelling here by local transit, please contact the transit info line at 604-953-3333 to ensure you have the most direct and timely route planned. If travelling by Greyhound, please contact your local depot for departure and arrival times. Please make sure your arrival time in Maple Ridge has been communicated to the admissions department.

Any changes in your original prescription must be reported to admissions department and it will be reviewed by the medical team prior to your intake date. Medical stability is a condition of admission into the program. Please ensure that you bring with you any third party medical coverage that you may have**. You are responsible for the costs of these medications**. On your admission day, MRTC will order a supply of your medications based on the prescription we receive in your referral package from your Doctor. We are required to collect any medications brought from home and will retain and return them upon discharge (except for Narcotic based medications). At the end of your stay MRTC will provide you with a 7 day supply of all your current medications.

Please bring the following items

- **Towels and toiletries**, shaving gear, toothbrush/paste, shampoo, deodorant, keeping in mind that MRTC is a Scent Free Facility. No alcohol based mouthwash is permitted
- Swim and workout gear (for exercise at community centre)
- Free time activities ie. Books, painting supplies, musical instruments. Please ensure that you do not bring any distasteful or inappropriate reading material to the Centre.
- Weather appropriate clothing with no drug/alcohol ads or logos, nor with any racial, sexist, gang or homophobic propaganda on it.
- Coins for pay phones, phone card – you will have access to your own voice mail system
- Money for the laundry facilities. Our machines run on loonies or tokens that are purchased for $1 each. Each machine runs a full cycle on 1 token and soap is provided.
- Money for a Recreation Center / Gym pass. There is a minimal subsided fee for a 5 week pass or a 10 visit pass, please contact MRTC for the current costs.

Please DO NOT bring any of the following:

- Lap Tops, TV's, Portable DVD, Stereos, Tablets, IPads/Tablets, Smart Watches/Wearable Technology – anything that can record images (still or video) and/or audio etc.
- Medications/Vitamins – this includes prescription and over the counter drugs including but not limited to Tums, Tylenol, antihistamines, Gaviscon, vitamin, herbal or workout supplements etc. If your doctor has written a prescription for you on your referral package, we will fill it upon your admission to the Centre.
- Weapons – including pocket knives, laser pointers and martial arts items
- Food – No exceptions
- Vehicles (no parking is available)

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MRTC JOURNEY TO WELLNESS

Pre-Admission Medical Evaluation

Please complete this form with your patient

Physician: Please complete all 4 pages and fax to MRTC ATTN: Admissions Department at 604-466-6988.

Your patient is to be medically assessed as a potential participant in our residential treatment program. MRTC is not a medical facility, medications are administered as per your prescribed dose and directions. Our program is designed to help people who acknowledge that their drinking and substance use has interfered with their effective functioning and who are physically and mentally ready to participate in an intensive program. To assist MRTC in assessing this patient's suitability for treatment, and ongoing care while in treatment, please provide the following details.

Name of Patient:: ______________________________

Date of Birth: ______________________________

PHN# (Care Card): ______________________________

Name of Physician: ______________________________

MSP # ______________________________

Telephone Number: ______________________________

Fax Number: ______________________________

Mailing Address: ______________________________

____

Referral Date: ______________________________

DD MM YYYY

I hereby permit the exchange of information between Maple Ridge Treatment Centre and my Physician, any Mental Health office, Psychiatrist, Pharmanet, Health Records Departments or other medical staff involved in my care. This consent will expire in 12 months from the date below.

______________________________ ______________________________

Patient's Signature Date DD MM YYYY

✷ **Note: If the above consent is not signed, this referral will not be processed**

How long have you been caring for this patient?

☐ 0-3 Months ☐ 3-6 Months ☐ 6 –12 months ☐ 12 months or more

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MRTC JOURNEY TO WELLNESS

Medical / Psychiatric History:

please include lab or imaging results that may be relevant.

Problem list:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________

Allergies:

Drug Allergies: ____________________

Food Allergies: ____________________

Diet Restrictions: (medical or religious): ____________________

Dental Issues: ☐ Yes ☐ No ____________________

Dog Allergies: ☐ Yes ☐ No

Methadose / Suboxone clients: Please include UDS Flowsheet and if Methadose dosage is over 10ml/100mg, please supply most recent ECG.

Current dose __________ ml. Length of time on current dose: __________

Prescribing Doctor's name: ____________________MSP # __________

Phone number:____________________Fax:____________________

TB Screening:

Date: ____________________(must be within last 12 months)

Results: ____________________

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MRTC JOURNEY TO WELLNESS

<u>This prescription is intended for MRTC use and should only be filled upon admission to the Centre</u>

- **MRTC is not licensed to administer patient supplied medication.**
- Please write out all orders for a **5-week** supply for your patient to cover his stay with us.
- We require clients to bring originals of all triplicate prescriptions with them for their admission date.
- Methadose/Suboxone prescriptions should state **DWI at MRTC for 5 weeks.**

Date: ____

Patient Name: ____

PHN# (Care Card): ____________________________________

Rx **<u>PLEASE</u> PRINT CLEARLY – if not prescribing any medications, please indicate N/A** **- this page is required by our pharmacy for every client**

Physician's Signature: ______________________________ CPSBC#: ______________

Physician's Name, Please Print: __________________________ MSP # ________________

Thank you for taking the time to provide us with this important information.

Maple Ridge Treatment Centre
22269 Callaghan Ave
Maple Ridge BC
V2X 2E2

Tel:604-467-3471
Fax:604-466-6988
1-877-678-6782
www.mrtc.bc.ca

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MRTC JOURNEY TO WELLNESS

Pre-Printed Orders- Maple Ridge Treatment Center

Clients Name: ________________________________ **Allergies:** ________________________________

Medications

- Continuing and/or persistent presenting problem(s) requires medication consultation by the physician.
- ***Unless indicated otherwise, the above noted client is able to be administered the below noted OTC's***

Indication	Medication and Guidelines	Dr's Initials IF NO
Allergy (Seasonal)	**Cetirizine (Reactine)** 10mg tablets (dose: one to two tablets once daily to a maximum of 2 tabs(20mg) /day) up to 72 hours Consult physician if symptoms persist	
Allergic Reactions	**Diphenhydramine (Allerdryl)** 25mg Caps (Dose: one or two capsules every 6 hours X 24 hours) Consult physician if symptoms persist	
Constipation	Bowel protocol Sheet (**Starting day 5 of no bowel movement)**	
Cough	**Strepsils or Cepacol lozenges** as needed **Nim Jiom** cough syrup (dose: 15ml 3-4 times daily) *Consult physician regarding persistent, productive cough*	
Diarrhea	**Loperamide (Imodium)** (dose: 2 tabs stat then one after each loose bowel movement to maximum 8 tabs/24hours) *Consult physician if symptoms persist*	
Fever	**Acetaminophen (Tylenol)** (dose: 500-1000mg orally q6h PRN) For temperature above 38*C. *Notify physician ASAP during the work day.*	
Indigestion	**Magnesium/Aluminum suspension antacid (Maalox, Diovol)** (dose: 15-30ml orally q4h PRN X 24 hours) **and/or Regular Strength Calcium Antacid tablets (Tums)** (dose: 1 or 2 tablets every 4 hours as needed) For mild-epigastric pain without vomiting or cardiac symptomatology.	
Nausea	**Dimenhydrinate (Gravol)** (dose: 50mg orally q4-6h prn nausea X 24 hours **Ginger Gravol lozenges** (dose: 2 lozenges q4h to maximum of 6 loz/day)	
Pain	**Acetaminophen (Tylenol)** (dose:500-1000mg orally q4h PRN) **MAX 4gm/24hours** For headache, mild muscle or joint pain **Ibuprofen (Advil) 200mg tablets** (dose: one to three tablets up to three times daily) **MAX 2400mg/24hours** **May be used in combination for severe pain**	
Tooth Pain	**Oil of Cloves** (dose: apply as required up to four times daily) Consult physician for further treatment	
Smoking Withdrawal	Complete FTND or identify number of CPD. Initiate FH NRT PPO **PLEASE NOTE MAY ONLY BE STARTED BYNURSE** *Contact physician if required dose exceeds recommendations*	

Suspected Opioid Overdose	**Naloxone 0.4mg/ml**---Give **1ml** (0.4mg) intramuscularly every 3 minutes (until response achieved **or to a maximum of 5 doses**)	

This form will be valid for duration of stay.

________________________________ ________________________________

Date **Doctors Signature**