



PERSONAL INFORMATION

Full Name:	Date of Birth: mm/dd/yyyy	Gender Identity:
Phone Number:	HSN:	Treaty Number (optional):

CONSENT TO RELEASE INFORMATION

Client/Substitute Decision Maker (SDM) Signature

Client/SDM Statement: I authorize the information on this form to be shared with the Saskatchewan Health Authority Provincial Navigation Team and Saskatchewan Health Authority affiliated recovery treatment centres to support eligibility review, treatment placement, admission planning, and continuity of care. I understand the purpose of this disclosure, the risks and benefits of consenting to or refusing the disclosure of this health information, and that I may withdraw my consent at any time. I am providing this consent voluntarily and without coercion.

X

Signature of client or *substitute decision maker

SDM Printed Name

Date (mm/dd/yyyy)

***If consent is being provided by a Substitute Decision Maker (SDM), the SDM initials below the basis of authority based on The Health Care Directives and Substitute Decision Makers Act, 2015:**

- ☐ Proxy appointed under a health care directive
- ☐ A personal guardian appointed under *The Adult Guardianship and Co-decision-making Act*
- ☐ Nearest relative (where no proxy or guardian is appointed or available) – Relationship: _____

☐ **Verbal Consent** – only if impossible to get signature - Rationale: _____

☐ **Telephone/Virtual Consent** – Client identity verified by 2 unique identifiers (example: client's first/last name and birthdate). MRP/Designate to print the name of the client providing consent above in the signature spot OR, if an SDM, print the name of the SDM and complete the SDM Section to indicate the basis of authority.

☐ **Client Declined Consent** – Client must still sign the form above. Most Responsible Practitioner (MRP) to sign below. Do not complete any other sections.

Most Responsible Practitioner (MRP)/Designate Statement and Signature

Practitioner Attestation: I have explained to the client that the health information collected on this form may be disclosed to the Saskatchewan Health Authority Provincial Navigation Team and Saskatchewan Health Authority affiliated recovery treatment centres to support eligibility review, treatment placement, admission planning, and continuity of care. I have explained the risks and benefits of consenting to or refusing the disclosure and answered the client's/SDM's questions. In my opinion, the client/SDM has the capacity to consent and understands the information provided.

Full Name of MRP or Authorized Designate (first and last name)

Signature

Date (mm/dd/yyyy)

MEDICAL SCREENING

Assessed	Yes	No	Additional Information (If applicable)
Cardiovascular Concerns	☐	☐	
Seizure History	☐	☐	
Accessibility Needs	☐	☐	If yes, would they require wheelchair accessibility:
Cognitive/developmental concerns	☐	☐	
Stabilized for Treatment	☐	☐	
Communicable / Infectious Disease Concerns	☐	☐	Are there any active or untreated communicable/infectious disease concerns that may affect safe participation in a communal treatment setting? If yes, specify:
Allergies	☐	☐	If Yes, specify allergen(s) and reaction:
Diabetes mellitus	☐	☐	If Yes, specify type and current management/treatment.
Currently Pregnant?	☐	☐	If Yes, Gestational Age (weeks): _____ Expected Due Date: _____ Complications/ Concerns (if applicable):

Does the patient have any current or unresolved medical issue(s) that may require follow-up, monitoring, or treatment during admission? ☐ Yes ☐ No

If yes, specify: _____

MENTAL HEALTH

☐ No current mental health concerns identified.

☐ There are current mental health, behavioural, or safety concerns that may affect the patient's ability to safely participate in a communal inpatient treatment setting (aggression, active psychosis/mania, severe suicidality, significant cognitive impairment, or inability to participate safely in programming, etc.). Specify:

Please indicate the management plan to stabilize the patient prior to attending treatment (for example, initiating medications, follow-up with psychiatry):



Additional Mental Health Information:

CURRENT MEDICATIONS (Including over the counter [OTC] medications and supplements)

- ☐ Medication reconciliation completed (latest Pharmaceutical Information Program attached)
- ☐ Medication list provided below

Medication *Include OTC and supplements	Dose / Route/ Frequency	Purpose/Indication

SUBSTANCE USE / WITHDRAWAL CONSIDERATIONS

Substance	Currently Using?	Concern for Patient?	Last use:	Frequency of use:	Year started:	IV use:
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No				N/A
Benzodiazepines	☐ Yes ☐ No	☐ Yes ☐ No				☐ IV use
Opioids (fentanyl, heroin, oxycodone, hydromorphone, codeine or other)	☐ Yes ☐ No	☐ Yes ☐ No				☐ IV use
Other:	☐ Yes ☐ No	☐ Yes ☐ No				☐ IV use



INITIAL APPLICABLE BOXES

[illegible]

COMPLETED BY _____

MRP Name (print):

Date:

Signature: _____

Time: