Mobile Withdrawal Management Services
Referral Form

Fax: (204) 239-0551

Client Information

Legal Last Name:_____

Legal First Name: _____

Chosen Name (if different from above): _____

DOB: _____ Gender: _____
(DD-MMM-YYYY)

PHIN: _____ MFRN: _____

Referring Provider: _____

Referring Program: _____

Phone: _____

Fax: _____

Address: _____ **OR** ☐ No fixed address

City:_____Province:_____ Postal Code: _____

Has client consented to this referral? ☐Y ☐N

Please provide phone number(s) client can be reached at[1]:

_____ Can a message be left? ☐Y ☐N

Has this individual entered a detoxification program in a community or ambulatory setting in the past? ☐Y ☐N

If yes, please provide additional information:

_____

_____

_____

Eligibility Criteria[2]

Please indicate client meets eligibility criteria using the checkboxes below

- ☐ Client has no anticipated severe or complicated withdrawal including seizures
- ☐ Client is medically stable and deemed safe to be managed in a community setting
- ☐ Client is psychiatrically stable and deemed safe to be managed in a community setting

Substance(s) of Concern

Indicate primary substance

☐ Alcohol ☐ Cannabis ☐ Stimulants

☐ Benzodiazepines ☐ Opioids ☐ Other: _____

Date of last use: _____
(DD-MMM-YYYY)

Additional Information (optional):

_____

_____

_____

Please attach an addictions care plan or discharge summary including relevant medical and psychiatric history as well as the client's current pharmacy and medication(s).

[1] *If client does not have contact number, please call MWMS directly to arrange client intake.*

[2] *The MWMS team will attempt to reach client within 24 hours of receiving an eligible referral. You will be notified via fax if we are unsuccessful at contacting your client, they decline an appointment, or do not meet eligibility criteria.*