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WMS Pre–Admission Screening Assessment
Mental Health and Addictions

Client / Agency information

Client Name: ____________________ Date of Birth: __________ (dd/mm/yyyy)

Gender: ☐ M ☐ F ☐ Other: __________ Home town / city / location: ____________________

☐ Telephone screening / referral ☐ In–Person screening Date: __________ (dd/mm/yyyy) Time: ______ (hhmm)

Intake Screening Information Received From:

a) ☐ Client (telephone or in–person)

b) ☐ Niagara Health: ☐ PERT ☐ ED/UCC (Circle➔ SCS, GNG, WHS, PCG, DMH) ☐ NPC ☐ Outpatient Addictions

☐ Inpatient Mental Health ☐ OPMH ☐ Other (indicate): ____________________

Name / Status of referring staff: ____________________

c) ☐ Community agency / individual (name / agency): ____________________

Initial Screening and Problem Identification

1) Is the client:

a) Intoxicated / actively using substances and requests assistance in stopping use / withdrawal: ☐ Yes ☐ No

b) Currently or is at risk of experiencing withdrawal symptoms: ☐ Yes ☐ No

c) Wanting to voluntarily access WMS. ☐ Yes ☐ No

➔ If Yes to **a)** or **b)** then complete substance use questionnaire below:

Substance(s) Used	How long since last use?	Number of days used in past 30 days?	Typical amount on each day of use?	Comments (eg. drug name, dosage, patterns, withdrawal history, seizure history, when first started, etc.)
☐ Alcohol				
☐ Opioids				
☐ Cocaine / Crack				
☐ Amphetamines / other stimulants				
☐ Cannabis				
☐ Benzodiazepines				
☐ Hallucinogens				
☐ Tobacco				
☐ Glue / Other inhalants				
☐ Other psychoactive drugs (indicate)				

How long since last used: **1** = <24 hours **2** = 1–3 days **3** = within last week **4** = within last month **5** = >1 month ago

2) Client is in crisis? ☐ No ☐ Yes (type / describe): ____________________

3) Does client need assistance with housing, food, health care and / or other basic needs?

☐ No ☐ Yes (type / describe): ____________________

4) Is the client at risk of relapse? ☐ No ☐ Yes (type / describe): ____________________

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☐ **Admit to WMS**

1) **Assess for complex medical problems:** *indicate any known conditions in sections a) or b) below.*

a) **Does client have acute / emergent health conditions?** if **YES**, direct Client to ED prior to admission assessment

- ☐ Currently seizing or history of multiple seizures
- ☐ Threatening harm to self or others
- ☐ Suspected of having taken an overdose
- ☐ Uncontrolled insulin–dependent diabetic
- ☐ Cannot be roused, is unconscious or semiconscious
- ☐ Does not appear to be breathing or breathing is laboured, chest pains
- ☐ Acute psychosis, extreme agitation or confusion

b) **Does client have potential / non–emergent health conditions?**
If **YES**, refer to WMS NP on admission to WMS **OR** refer to SCS UCC following admission if WMS NP not available

- ☐ History of severe withdrawal complications (DTs, seizures)
- ☐ Suspects that she is pregnant
- ☐ Does not have their prescribed medication for a medical / psychiatric condition
- ☐ History of cardiac, respiratory, or severe medical problems
- ☐ Recent history of head injury with loss of consciousness or other injury / trauma
- ☐ History of intense drug usage (eg. long–term use of benzodiazepines)
- ☐ Severe vomiting / diarrhea and is at risk of dehydration from fluid loss
- ☐ Medication controlled diabetic who has not been eating regularly
- ☐ Physical presentation does not match the information provided on substances used

2) **Bed assigned** ☐ No ☐ Yes Bed #

3) **Informed of items to bring/not bring to WMS** ☐ Yes

4) **Prescribed medications?** ☐ No ☐ Yes ➔ Informed to bring medications in labelled containers

5) **Prescribed ORT?** ☐ No ☐ Yes ➔ ☐ Methadone ☐ Suboxone® ☐ SRM ☐ Diacetylmorphine ☐ Other

6) **Informed of NH WMS smoking policy?** ☐ Yes

7) **Reviewed safe transportation to WMS?** ☐ Yes

8) **Client has children in care and has childcare arranged so Client can attend WMS?** ☐ No ☐ Yes ☐ N/A

☐ **Non–Admit to WMS**

☐ **Client using substances or at risk of withdrawal but refuses admission to WMS**	☐ RAAM Clinic 905–378–4647 Ext. 49463 (self–referral) ☐ CASON 905–684–1183 ☐ Mental Health & Addictions Access Line 1–866–550–5205 ☐ Other:
☐ **Client is in a self–identified crisis and/or needs assistance with housing, food, health care or other basic needs.** ★ *Client not identifying substance use problems that meet WMS admission criteria.*	☐ Mental Health & Addictions Access Line 1–866–550–5205 ☐ Other:
☐ **Client at risk of relapse but has not used substances**	☐ Brief counseling on relapse prevention ☐ CASON 905–684–1183 ☐ Mental Health & Addictions Access Line 1–866–550–5205 ☐ Other:

Notes: ______________________________

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Name and Status _______________ Signature _______________ Date (dd/mm/yyyy) _______________

Length of Screening Call / Contact: _________ minutes ☐ Catalyst data entry completed

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