URN:
Family Name:
Given names:
Address:
Date of birth:

Affix patient identification label here

Sex: ☐M ☐F

WA Toxicology Service

Alcohol & Drug Service

Date: ___/___/20___

Time: _____hrs

Emergency Department Prescription and Recreational Drug Screening Tool

Complete on all patients when assessable.

(If not expected to be assessable on your shift discuss with accompanying person(s). Repeat with patient when awake.)

If DARK ORANGE or RED, consider referral to Alcohol and Drug Service (ADS) and commencement of appropriate withdrawal protocol. Where asterisk (*) and RED, all should be referred to ADS where possible.

Screening Interview completed with: ☐Patient ☐Partner/Spouse ☐Family/Friend ☐Other_____

Arrival Mode: ☐SJA ☐Self ☐Family/Friend ☐Police ☐Prison ☐RFDS ☐Other_____

Presenting Complaint:_____

_____

1. ALCOHOL

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Usual type (circle) Beer / Wine / Spirits or other (specify):_____

Amount: _____ (circle) Bottles / Can / Litres / Millilitres each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known):_____

2. AMPHETAMINES (includes hallucinogenic [i.e. MDMA/ecstasy], dexamphetamine, crystal/ice etc.)

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Type(s):_____

Routes:_____

Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known): _____

3. SYNTHETIC RECREATIONAL DRUGS (includes synthetic cannabis [spice/kronic], bath salts, NBOME etc.)

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Type(s) and Brand (if known): _____

Routes: _____

Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known):_____

Type and Brand (if known) of last used synthetic product(s):_____

4. CANNABIS

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known):_____

5. BENZODIAZEPINES (includes diazepam, temazepam, lorazepam, alprazolam, zolpidem etc.)

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Name : _____ Amount: _____ (circle) each Day / Week / Month on average.

Name : _____ Amount: _____ (circle) each Day / Week / Month on average.

Name : _____ Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown Date last used (if known):_____

6. OPIOIDS (includes fentanyl, oxycodone/OxyContin, methadone, buprenorphine, heroin, codeine etc.)

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Name : _____ Amount: _____ (circle) each Day / Week / Month on average.

Name : _____ Amount: _____ (circle) each Day / Week / Month on average.

Name : _____ Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known):_____

Type and Brand (if known) of last used opioid product(s): _____

Coding [tick if Y]:
☐ Refer
☐ App. Refer
☐ Entered

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7. PRESCRIPTION, OVER COUNTER OR HERBAL DRUGS USED FOR NON-MEDICAL REASONS

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

1) Name : _____ **Date last used** : _____

Amount : _____(circle) Tabs / Boxes / Other: _____ (circle) each Day / Week / Month on average.

2) Name : _____ **Date last used :** _____

Amount : _____(circle) Tabs / Boxes / Other: _____ (circle) each Day / Week / Month on average.

3) Name : _____ **Date last used :** _____

Amount : _____(circle) Tabs / Boxes / Other: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known):_____

Type and Brand (if known) of last used therapeutic product(s):_____

8. INHALANTS (includes nitrous oxide, glue, petrol, gas, paint thinner, toluene etc.)

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Type(s): _____

Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known): _____

9. HALLUCINOGENS (includes LSD, acid, mushrooms, PCP, Ketamine etc.)

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Type(s) and Brand (if known):_____

Routes:_____

Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known): _____

Type and Brand (if known) of last used synthetic product(s): _____

10. COCAINE

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Amount: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known):_____

11. TOBACCO or NICOTINE PRODUCTS (includes gum, patch, vaporisers etc.)

☐Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily*

Amount : _____(circle) Cigarettes / Boxes / Other: _____ (circle) each Day / Week / Month on average.

Used in Last 24 hours? ☐ Yes ☐ No ☐ Unknown. Date last used (if known): _____

Request for Review by Alcohol and Drug Service or Senior Physician Following Screening

(Note: ADS at SCGH currently operates Monday through Saturday only. If out of service hours, discuss with senior physician.)

ALCOHOL AND DRUG SERVICE

Review is requested /not required / out of service hours (circle). _____(ED RN/MO sign) at _____hrs.

(Place form in ADS box at main fly desk or Obs ward. Page service if urgent or if screened after 1100hrs.)

☐ ADS unable to review due to patient mental state/sedation or patient acuity, please contact when the patient is assessable.

☐ ADS unable to review as patient off ward, please contact when the patient has returned.

_____(ADS sign) _____hrs. *(ADS place form in patient file)*

☐ Patient reviewed by ADS, please see notes for assessment and treatment recommendations.

☐ Not seen by ADS – discussed with team, patient notes or history indicates patient not required to be seen at this time.

_____(ADS sign) _____hrs. *(ADS place form in patient file)*

TREATING MEDICAL TEAM

Symptomatic /suspicion of toxidrome inform senior Dr. _____(ADS/ED RN/MO sign) at _____hrs.

DISPOSITION

☐ Home ☐ Police ☐ Ward ☐ Inter-Hospital T/F ☐ RIP Discharge Diagnosis _____

Discharge Date: _____at _____hrs. _____ (ED RN/MO sign)

(Return form to Toxicology box at main fly desk following discharge. Do not file in inpatient notes.)

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