Centre intégré de santé et de services sociaux de la Montérégie-Ouest
Québec

Facility: _____

File no.: _____

Family name, first name: _____

Date of birth: _____ ☐ F ☐ M
YYYY-MM-DD

RAMQ no.: _____ Exp. _____
YYYY-MM

Mother's name: _____

USER'S DEPARTURE - PSYCHOSOCIAL INPATIENT ADDICTION TREATMENT PROGRAM

IDENTIFICATION OF REFERRING PERSON

Referring person's name: _____ Point of service: yyyy/mm/dd

Admission date: yyyy/mm/dd Expected end date of stay: yyyy/mm/dd

Discharge date: yyyy/mm/dd

OUTCOME OF PROGRAM

☐ **Early departure**

I hereby voluntarily terminate my participation in the inpatient readaptation program, and I release the CRD of all liability concerning me.

Reason(s) for early departure (reasons reported by the user): _____

☐ **Refusal of care and services**

I hereby acknowledge that I voluntarily and knowingly refuse the care and services offered to me. I have been informed by the nursing staff of the possible risks associated with my refusing to accept treatment.

Reason(s) for refusing care and services: _____

☐ **Sent back**

Reasons for being sent back: _____

☐ **Reorientation** ☐ **Transferred to hospital** ➔ Reasons: _____

USER'S EXIT PLAN

☐ Presence of cravings	☐ Yes	☐ No	☐ If **Yes**, discussed how to prevent a relapse
☐ Presence of suicidal ideation	☐ Yes	☐ No	☐ If **Yes**, see the G*rille d'estimation de la dangerosité d'un passage à l'acte suicidaire (CLI-60242)*
☐ Presence of homicidal ideation	☐ Yes	☐ No	☐ If **Yes**, see the G*rille homicidaire*
☐ Appointment scheduled	☐ Yes	☐ No	☐ If **No**, was the user told to call the outpatient department to make an appointment?
☐ Outpatient appointment reminder	Date: _____		Worker: _____
☐ User agreed to contact a friend/family member to notify them of their departure	☐ Yes	☐ No	Person contacted: _____

ADDITIONAL INFORMATION

_____

_____

_____

User's signature _____ Date: yyyy/mm/dd

Signature and title _____ Date: yyyy/mm/dd