Drug Withdrawal

OBTAIN VERIFICATION OF CURRENT MEDICATIONS: Prescription bottles or ROI to MD

Subjective: Time Last took Medication:

Amount, duration, and frequency of drugs consumed prior to incarceration:

Other medication taken:

Alcohol taken:

Hx of: □ Diabetes □ hypertension □ seizures □ other medical problems

Patient complains of:

☐ Nausea ☐ Vomiting ☐ Feelings of nervousness
☐ Headache ☐ Tremors Where?
☐ Visual Disturbances ☐ Tactile Disturbances ☐ Auditory Disturbances
☐ Oriented to day, place, person ☐ Hallucinations

Objective:

Vital Signs: BRAC _______ Temp _____ Pulse ____ Resp _____ B/P _____ Blood Sugar______

Oriented X 3 _______ ☐ Alert ☐ Hallucinating

Evidence of sweating: ☐ mild ☐ moderate ☐ severe

Evidence of tremors: ☐ mild ☐ moderate ☐ severe

Irritability: ☐ mild ☐ moderate ☐ severe

Diarrhea: Color/ frequency

Seizure: Description

Affect: ☐ Labile ☐ Stable

Findings: ☐ Acute ☐ Possible Drug Withdrawal from ________________

Actions:

Drug withdrawal requires contacting the Medical Provider and Mental Health for individualized medication orders and treatment plan.

*If the patient is on Benzodiazepines abrupt withdrawal is contraindicated.

If patient shows signs of even just mild symptoms of withdrawal, tremulousness, irritability, anorexia, nausea, and occasional hallucinations call practitioner to initiate detox protocol and obtain individualized medication and treatment orders:

1) Vital Signs TID up to every 6 hours to include blood pressure, heart rate, and temperature
2) Notify facility provider or on-call provider any time:
   a. BP < 90/60 mmHg [or] BP > 180/110 mmHg
   b. New onset of HR < 60 [or] HR > 120 bpm sustained for more than 15 minutes
   c. Temp > 101 F
   d. Nausea or vomiting despite treatment
   e. Clinical Opiate Withdrawal Score (COWS) increases by ≥ 6 points from initial score despite treatment
   f. Pregnancy: alternate withdrawal medications must be used in pregnancy
3) Alert provider if chronic use of alcohol is known or suspected; consider Thiamine in such cases.

Provider contacted: __________ Date & Time: __________
Orders received: ________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
Nurse's Signature: ___________________________