

# Day, Evening and Weekend (DEW) Substance Use Treatment Program



## Client Information:

Last Name:                                      First Name:                                      Middle Initial:                                      Preferred Name:

Date of Birth:                                      Identified Gender:                                      Pronouns:

Home Address:

Email Address:

Preferred contact #:                                      (Primary)                                      (Alternate)

Client Preferred days / times to be contacted:

PHN # (if known):                                      PARIS ID (if known):

- Client is aware of and consents to this referral to the DEW program.
- Client has received information about the groups offered (Schedule available here: [www.fraserhealth.ca/dew](http://www.fraserhealth.ca/dew)).
- There are no current safety concerns (acute risk to self or others) that would preclude participation in group treatment.
- Client is aware the DEW program will contact them to discuss their treatment plan.

Other considerations and recommendations for supporting the client:

## Information about referral source:

Date of referral:

Referrer name (First and Last):                                      Organization:                                      Role:

Referrer phone #:                                      Fax #:                                      Email:

**Complete and Fax back to 604-585-5625**