

Substance Use Residential Treatment Referral Form

Using a bio-psychosocial-spiritual assessment and trauma informed approach, complete this referral at the pace of the person to be referred.

Introductory section:

A: Indicate how the person describes his/her current situation and the impact of substance use in each life domain:

- **Mild effect:** the person is experiencing minor consequences and some change of functioning.
- **Moderate effect:** the person has experienced negative consequences and some loss of function
- **Significant effect:** the person is unable to carry out responsibilities and to function effectively.

B: Indicate the person’s reported current engagement in most substance use treatment services by checking the box that applies.

C: If response is yes, mothers and young children can access specific services.

D: Please answer if the person is attending withdrawal management and if not, what is the reason. If yes, indicate the planned date of completion. People who have unstable concurrent medical or psychiatric issues, are using more than one substance, and/or those who have a history of or are deemed at risk for complicated withdrawal syndromes (ie: seizure disorders; delirium tremens; alcohol use disorder; benzodiazepine and barbiturate use) need to be assessed for supervised withdrawal.

Personal Information:

Complete this form in collaboration with the person.

- Referral Source information: You must provide direct contact details for the clinician responsible for all contact regarding the referral. This will be the person we contact.
- Current location: Select from drop down. Details of tertiary sites to include: Forensic Hospital, Burnaby Centre for Mental Health and Addictions or Heartwood Women’s Treatment Centre

Substance Use Information:

- Indicate English language proficiency.
- Indicate the person’s wishes, and if they are willing and able to commit to the requirements of residential treatment
- Complete the table for all substances used
- Detail what treatment/services has been tried to date

Health information:

- Include relevant physical and mental health information and include collateral as relevant
- TB test date, if within the past year, the person will not require a new screening. TB tests are to be completed, as required by licensing, within 30 days of intake. Thus, it is encouraged that the TB test is completed before arriving.
- Detail all medications with dose, frequency and prescribing doctor

Legal & Financial Information:

- Please include any upcoming court dates for consideration of admission date, as well as copies of orders
- Financial Information:
 - source of payment must be confirmed
 - persons with Aboriginal status or veterans may be eligible for federal funding
 - if the person is eligible for income assistance, then suggest that they apply at www.myselfserve.gov.bc.ca.
 - if the person is not eligible for income assistance but still requires supplemental income, complete an Accommodation Fee Subsidy form and send it to afs@fraserhealth.ca in tandem with the referral

Other Relevant information:

- Safety considerations: please include significant areas of risk and the source of information.
- Provide person specific choices. People are eligible for Aboriginal program beds regardless of ethnicity

Signature/consent:

Inform the person that the program is voluntary, that they have a right to know the details of the program and the expectations, that they have the right to know the complaint process and to expect follow-up. A signature by the person indicates they agree to the referral, the cost and for the release of information for the purpose of the referral.

Note: Referrals must be typed and complete to be screened

Required: Early Exit Plan Attached

Supporting Documentation – Required if Applicable: check if included

- Medical report on physical condition Recent psychiatric assessment (within 3 months)
 Multidisciplinary reports/assessments (social work, nursing notes) Neuro/cognitive assessment
 Recent addiction physician assessment (within 3 months) Probation conditions and/or court orders

A: How does the person report the impact of SU on their:	Mild Effect	Moderate Effect	Significant Effect
Social environment (<i>friends, relationships</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Support system (<i>may include family, or natural supports.</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocation / education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B: Engagement with Substance Use Services	Engaged but experiencing difficulties - minimal or no use	Not Engaged experiencing coping difficulties - minimal or no use	Engaged with intermittent use and some life disruptions	Engaged with high use, distress and life disruptions	Not Engaged with high use, distress and life disruptions
<i>Please indicate how the person describes service engagement & challenges with use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C: Does this person have pre-school age children that will accompany them to treatment? Yes No

D: Does this person require supervised medical withdrawal management services? Yes No N/A
 Is medically supervised withdrawal management scheduled? Yes No If no, reason:
 If yes, what date is withdrawal management expected to be completed:

Personal Information

Person Referred:

Last Name: _____ First Name: _____

Other name / preferred name: _____

Gender _____ Preferred gender pronoun(s): _____

Date of Birth: _____ PHN# (Care Card): _____

What are the person's current living arrangements?: _____

Home Address: _____

City: _____ Postal Code: _____

Current location (*if different from above*): _____ Details: _____

Primary Phone: _____ Email: _____

Person's preferences regarding contact: days evenings

OK to leave message? Yes No

Alternative/Emergency contact Name: _____

Phone: _____ Email: _____

Proficient in written English?: Yes No Proficient in verbal English?: Yes No

Does the person require an accommodation to participate with written materials in program? If yes, please provide details:

Marital Status: _____ Dependents: Yes No

What is the person's current employment / vocational status:

Referral Source: *All correspondence will be sent to both email addresses listed for continuity of care*

Name: _____ Agency: _____
 Email #1: _____ Email #2: _____
 Office phone: _____ Cell: _____ Fax: _____
 Who will provide support during their stay?: _____

Substance Use Information

What is this person hoping most to get from treatment?

 What does this person say supports their recovery and what does not?

Substances Used	Primary Substance Identified	Is the Person seeking treatment for this substance use?	Date of Last Use	Typical Amount	Frequency Last 30 Days
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				

Safety Planning

Does the person have a safety plan when using substances? Yes No
 In the previous 6 months, has the person had any incidences of overdose? Yes No
 If yes: *Choose all that apply*
 Further details:

Substance Use Treatment History			Program Completed Y / N
Service Accessed	Dates	Service Provider	
Withdrawal management			
Outpatient or Counseling <small>(please complete next question)</small>			
OAT <small>(Opioid Agonist Treatment)</small>			
iOAT <small>(Injectable Opioid Agonist Treatment)</small>			
STAR <small>(Short-term Transitional Access to Recovery)</small>			
STLR <small>(Stabilization & Transitional Living Residences)</small>			
IRT <small>(Intensive Residential Treatment)</small>			

➔ Outpatient Counselling - Indicate number of sessions completed and if applicable reason for early exit:

Health Information

Mental Health

Does the person have a diagnosed mental illness for which they are receiving mental health services? Yes No

If yes, please provide Diagnostic Category/Primary Focus:

Mental Health clinician/psychiatrist contact name:

Phone: _____ Email: _____

Has the person experienced any of the following in the past 6 months:

Non accidental self-injury Suicide attempts/chronic ideation Details:

Hospital admissions for mental health reasons over the past 6 months? Yes No

If yes, please provide details: *(ie. admission date, location)*

Is the person on, or plan to be on, extended leave under the Mental Health Act Yes No

Does the person have any history of process addiction?:

Physical Health

Current Opioid Agonist Therapy (OAT)? Yes No Methadose: Yes Suboxone: Yes Kadian: Yes

Current OAT dose: _____ Length of time on current dose: _____

Prescribing OAT Physician _____ MSP#: _____

Ph: _____ Fax: _____

List all current medications *(attach MAR or separate document if needed)*. Be sure to include medication name, dosage, length of time on medication and prescribing doctor:

Does the person have mobility challenges? Yes No

If yes, please indicate:

Does the person have vision or hearing impairments? Yes No

If yes describe

Does this person require assistance with self-care? Yes No

If yes describe

Does the person have chronic pain? Yes No

If yes describe

Does this person have dietary needs **not related** to food allergies? Yes No

Details:

Allergies: *(Food, Medication or Environmental etc.)* Yes No

List:

Other health considerations:

Tuberculosis Test: last known date:

Physician's Name: Agency:

Phone: Fax: Email:

Legal & Financial Information

Legal

Has the person been / is the person involved with the Courts/ Criminal Justice System? Yes No

If yes, please complete the following **and attach a copy of probation orders or court orders:**

Primary corrections contact name:

Office: Phone:

Email:

Provide details in chronological order (including convictions):

Please indicate if any of the following apply: *Choose all that apply*

Please provide details, including pending court dates:

Financial

Served in Canadian military: Yes No Aboriginal status card #

Canadian citizen: Yes No - if no, current status:

Plan G coverage: Yes No

Third part Pharmacy coverage: Yes No Indicate:

How will the user fee be paid:

Income assistance (has an application been made? Yes No)

employer private insurance self request for accommodation fee subsidy

Aboriginal Services Veteran's Affairs First Nations Health Authority

Payer information:

Name of Person or Agency/Company (if other than I.A. or AFS):

Phone: Email:

Other Relevant Information

Other Agency involvement: Yes No

If yes, please provide details:

Safety considerations? Yes No If yes details (ex: fire risks):

Are there any spiritual or religious practices/ceremonies that will support the person's wellness while in a residential facility:

Are there preferences in the types of programs offered at the residential program?: *Choose all that apply*

Details regarding preference:

Geographic preference:

Fraser North, including Burnaby, Tri Cities, New Westminster, Maple Ridge

Fraser South including: Surrey

Fraser East including: Abbotsford, Chilliwack, Agassiz

Indicate if person has a preferred residential program in mind?

Signatures/Consent:

Has the person been oriented to his/her rights? Yes No (see guide)

By signing below, I consent to following:

- This referral is being submitted for consideration to Fraser Health Substance Use Residential Treatment Services
- The information in this referral and any supporting documentation being released and shared between my Community Care Team, Regional Fraser Health central team and Substance Use Services Contracted Service Providers
- My Community Physician will be sent an admission and discharge summary

This consent will expire 6 months from the date below.

Signature: _____ Date: _____
Client Signature DD MM YYYY

I authorize contact by Fraser Health with _____ for the purpose of user fee payment

Signature: _____ Date: _____
Client Signature DD MM YYYY

Signature: _____ Date: _____
Referral Signature DD MM YYYY