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SUBSTANCE USE BED BASED TREATMENT & SUPPORTED LIVING
18 yrs and Under 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. Please answer if the person is attending withdrawal management and if not, what is the reason. If yes, indicate the planned date of completion. Medical screening may be required. 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 (i.e. seizure disorders; delirium tremens; alcohol use disorder; benzodiazepine and barbiturate use) need to be medically 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

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 bed based 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 screening date, if within the past 6 months, the person will not require a new screening. TB screenings are to be completed, as required by licensing, within 30 days of intake. Thus, it is encouraged that the TB screening is completed before arriving.
- Detail all medications with dose, frequency and prescribing doctor.

Legal Information:

- Please include any upcoming court dates for consideration of admission date.

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, guardian (if applicable) and the relationship of the guardian, indicates they agree to the referral, and for the release of information for the purpose of the referral.

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Note: Referrals must be typed and completed to be screened

Required: **Early Exit/Wellness Plan Attached**

Supporting Documentation – Required if Applicable: ***check if included***

- Medical report on physical condition
- Multidisciplinary reports/assessments (social work, nursing notes)
- Recent addiction physician assessment (within 6 months)
- Recent psychiatric assessment (within 6 months, if available)
- Neuro/cognitive assessment

A. How does the person report the impact of SU on their:	Mild Effect	Moderate Effect	Significant Effect
Social environment (friends, relationships)			
Primary Support system (may include family, or natural supports.)			
Vocation (work) / education			
Housing			
Health (e.g. mental, physical)			

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
Please indicate how the person describes service engagement & challenges with use					

C. 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? **--Choose--**

Home Address:_____

City:_____ Postal Code:_____

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

Primary Phone: _____ Email: _____

Person's preferences regarding contact: **--Contact Preferences--** Days Evenings

OK to leave message? Yes No

Alternate/Emergency contact? Name:_____

Phone:_____ Email:_____

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

Person's Legal Guardian:_____

Does the person have any learning needs (e.g. written materials)? If yes, please provide details:

_____

Relationship Status: --Choose--

What is the person's Vocational/Education status: --Choose--

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

Name:_____ Agency:_____ Role:_____

Email #1:_____ Email #2:_____

Office phone:_____ Cell:_____ Fax:_____

Who is the most responsible Clinician / Case Manager?_____

Substance Use Information

What is this person hoping most to get from treatment (e.g. Goals)?

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
--Identify Substance--		Yes No	--Select--		--Choose--
--Identify Substance--		Yes No	--Select--		--Choose--
--Identify Substance--		Yes No	--Select--		--Choose--
--Identify Substance--		Yes No	--Select--		--Choose--
--Identify Substance--		Yes No	--Select--		--Choose--
--Identify Substance--		Yes No	--Select--		--Choose--
--Identify Substance--		Yes No	--Select--		--Choose--
--Identify Substance--		Yes No	--Select--		--Choose--

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(s)? Yes No

If yes, choose all that apply: Emergency Services Attended Emergency Department

Admission to Hospital Overdose - no EMS Services

Further details: _____

_____

Substance Use Treatment History

Service accessed	Date(s)	Service Provider	Program completed Y/N
Withdrawal management			Yes No
Outpatient Counseling ***(please complete number of sessions question below)***			Yes No
OAT (Opioid Agonist Treatment)			Yes No
Day Treatment			Yes No
STLR (Stabilization & Transitional Living Residences)			Yes No
IRT (Intensive Residential Treatment)			Yes No
Other:			Yes No

► Outpatient Counselling – Indicate number of sessions completed:

1-3 4 or more N/A

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 (Psychosis?): --Choose--

If no, does the client identify any undiagnosed symptoms? _____

_____

Mental Health clinician/psychiatrist contact name:_____

Phone:_____Email:_____

Hospital admissions for mental health reasons over the past 6 months? Yes No Details: (i.e. admission date, reasons, 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#:_____

Phone:_____ Fax:_____

Pharmacy used:_____

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: --Choose--

Does the person have vision or hearing impairments? Yes No Details:_____

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

Does the person have chronic pain? Yes No Details:_____

Does this person have dietary needs **not related to** food allergies? (i.e. cultural considerations) Yes No

Details:_____

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

List:_____

Other health conditions: _____

Tuberculosis Screening - last known date:_____

Physician's Name:_____ Agency:_____

Phone:_____ Fax:_____

Email:_____

Legal Information

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

If yes, please complete the following:

Primary corrections contact name:_____

Office:_____ Phone:_____

Email: _____

Provide details in chronological order: _____

_____

Please indicate if any of the following apply:

Probation Community Service Order (CSO) Currently on Bail Other:_____

Please provide details, including pending court dates:_____

_____

Other Relevant Information

Other Agency involvement: Yes No Details:_____

Safety considerations? Yes No Details (ex: fire risks, violence):_____

Are there any spiritual or religious practices/ceremonies that support the person's wellness in a bed based & supported living program?

_____

Indicate if person has a preferred bed based & supported living program in mind?_____

Signatures/Consent

Has the person been informed that the program is voluntary? Yes No

Has the person been informed of the details of the program? Yes No

Has the person been informed of the program expectations? Yes No

Has the person been informed of the complaint process? Yes No

By signing below, I consent to following:

- This referral is being submitted for consideration to Fraser Health's MHSU Bed Based Treatment & Supported Living Program.
- The information in this referral and any supporting documentation being released and shared between my community care team, Referral Coordination Service and substance use service provider.
- I would like my community physician or nurse practitioner to be sent an admission and discharge summary?

Optional: Yes No

This consent will expire 6 months from the date below.

Signature:_____ Date:_____
Client Signature DD MM YYYY

Signature:_____ Date:_____
Legal Guardian Signature (If applicable) DD MM YYYY

Signature:_____ Date:_____
Referral Agent Signature DD MM YYYY