# RESIDENTIAL TREATMENT FOR SUBSTANCE USE

## Referral Form Instruction Guide

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, mother's and young children can access specific services. Programs that accommodate this need can be found on the Fraser Health Pulse page: Substance Use Referral Options.

**D**: Please answer if the person is attending withdrawal management and, if not what is the reason. If yes, indicate the 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).

### 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.

### Substance Use Information:

- Optional: ethnic/cultural heritage assists with statistics
- 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
- 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.
- **Important Note: Prescription Medication:** attach a Phamanet medication history or list of medications.

### Legal & Financial Information:

- Please include any upcoming court dates for consideration of admission date.
- Financial Information:
  - source of payment must be confirmed
  - persons with Aboriginal status or veterans may be eligible for federal funding
  - if the person is on or applying for income assistance, please ensure the Confirmation of Income Form (page 5) is signed.

### Other Relevant information:

- Safety considerations: please include significant areas of risk and 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. .

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Better health. Best in health care.

Substance Use Residential Treatment
# Referral Form

Fraser Health Mental Health and
Substance Use Services
Fax: 604-519-8538

## Introductory section:

| **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 / education | ☐ | ☐ | ☐ |
| Housing | ☐ | ☐ | ☐ |
| Health | ☐ | ☐ | ☐ |

| **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 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)*:

Primary Phone: Email:

Person's preferences regarding contact: ☐ days ☐ evenings

OK to leave message? ☐ Yes ☐ No

Consent to alternate contact? ☐ Yes ☐ No Name:

Phone: Email:

Optional: ethnic / cultural heritage:

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:**

Name: Email:

Agency:

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 |
|---|---|---|---|---|---|
| | ☐ | | | | |
| | ☐ | | | | |
| | ☐ | | | | |
| | ☐ | | | | |
| | ☐ | | | | |
| | ☐ | | | | |
| | ☐ | | | | |
| | ☐ | | | | |

**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 (please complete next question) | | | |
| OAT *(Opioid Agonist Treatment)* | | | |
| iOAT *(Injectable Opioid Agonist Treatment)* | | | |
| STAR *(Short-term Transitional Access to Recovery)* | | | |
| STLR *(Stabilization & Transitional Living Residences)* | | | |
| IRT *(Intensive Residential Treatment)* | | | |

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

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 is there a plan for the person to be on, extended leave? ☐ Yes ☐ No

**Physical Health**

Does the person have mobility challenges? ☐ Yes ☐ No

If yes, please indicate:

Does the person have vision or hearing impairments? ☐ Yes ☐ No

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

If yes describe

Does the person have chronic pain? ☐ Yes ☐ No

Does this person have dietary needs **not related** to food allergies?

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

List:

Other health considerations:

Tuberculosis Test: last known date?

Physician's Name: Agency:

Phone: Fax: Email:

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:

## 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:

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**

Aboriginal status: ☐ Yes ☐ No Served in Canadian military: ☐ Yes ☐ No

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

Third part Pharmacy coverage: ☐ Yes ☐ No Indicate:

How will the user fee be paid?

☐ employer ☐ private insurance ☐ self ☐ request for accommodation fee subsidy

☐ Aboriginal Services ☐ Veteran's Affairs

Payer information:

Name of Person or Agency/Company:

Phone: Email:

## Other Relevant Information

Other Agency involvement: ☐ Yes ☐ No

If yes, please provide details:

Safety considerations? ☐ Yes ☐ No If yes details (e

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

Does the person have a preferred residential program in mind? ☐ Yes ☐ No

If yes indicate program:

## 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

**Note: Referrals must be typed and complete to be screened**

**Referral Form Checklist for Required Supporting Documentation:**

☐ Current treatment plan, including early exit planning
☐ MAR or list of medication

BRITISH COLUMBIA Ministry of Social Development and Social Innovation

# CONFIRMATION OF INCOME

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The information will be used for eligibility purposes. The collection, use and disclosure of personal information are subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Questions regarding the collection, use, and disclosure of personal information can be directed to an Employment and Assistance Worker by phone at 1-866-866-0800.

| Service Provider Name | Fax Number |
|---|---|
| Address | |

Clients receiving assistance from the Ministry of Social Development and Social Innovation must inform the Ministry of their request to enter residential care/treatment prior to funding. The Ministry will process applications for funding once notified of the client's arrival on the date of admittance by the facility faxing the HR3319 to the Ministry of Social Development and Social Innovation.

| Client Full Name | | |
|---|---|---|
| Phone Number | Date of Birth | SIN Number |

I hereby authorize the staff from the Ministry of Social Development and Social Innovation to release information from my file required to establish eligibility for funding. This includes any income received or pending, and any missing documents that might affect my eligibility.

Client Signature _____ Date Signed _____

**To be completed by ministry staff**

Does the client have an open file? ◯ Yes ◯ No

Is the client receiving any other income? ◯ Yes ◯ No

Source of income _____

Amount of income _____

Is the client pending any other income? ◯ Yes ◯ No

Source of pending income _____

Notes

Ministry Staff Signature _____ Date Signed _____

*Be advised information is accurate as declared to the Ministry as of the date signed.