PEARDONVILLE HOUSE
TREATMENT CENTRE

Mom & Kids - Referral Package Completion Checklist

This referral package must be completed by a drug and alcohol counsellor, a therapist, a mental health worker, a health care professional or a community support worker in collaboration with the client.

Before submitting your referral package, please ensure the following tasks are complete:

- ☐ Case Manager is assigned to the client and has
  - ☐ Filled out their contact information on page 3
  - ☐ Completed page 4 with the client
  - ☐ Assisted with page 7, 8, 9, 16, 17, 18, 23, 24 including signatures
  - ☐ Completed Assessments - Pages 25-29
- ☐ Funding verification provided – Page 6
- ☐ Early Exit Transition Plan complete and attached
  Plan must be accurate & feasible and Cost provided upon intake – Page 7
- ☐ Pages 10-15 completed by a Physician
- ☐ Pharmanet form signed and witnessed – Page 16
- ☐ Child paperwork completed and attached – Pages 19-24
- ☐ Copy of moms photo ID and any piece of ID for child faxed to Peardonville House
- ☐ Review Client Checklist of What to Bring and What Not to Bring – Page 30. **Give sheet to client**
- ☐ TB test complete and attached
- ☐ Inform client to call intake weekly to check-in. Clients can leave a message and intake will respond if needed.

MHSD Funding Verification Instructions:

1. Complete the top part of the form with client name and SIN# and the Referral agent details.
2. Client must take the form to their ministry office who will complete it and fax it back to the referral agent
3. Please send the completed form together with the referral application
4. For all other funding, please follow the instructions on the Funding Information Sheet in your referral package.

PEARDONVILLE HOUSE
TREATMENT CENTRE

Three programs with one purpose:
To stop the cycle of substance misuse, one woman at a time.

Mollie's House

Mollie's house is part of our Stabilization program for women who are seeking a safe haven from chronic substance misuse but who are not yet ready for an intense residential treatment program. The goal of the stabilization program is to empower women to overcome barriers, meet their basic needs and teach life skills that help women to be successful in their transition to either the intensive program or back into the community.
Residents of Mollie's House are encouraged to participate in a modified treatment program at their own pace. The stabilization program is 60 days or 90 days in duration. Clients may then have the opportunity to move into our intensive program.
Women who might benefit most from Mollie's house are those with the following challenges:

- Concurrent Mental Health disorders
- Brain Injury
- Learning Disability
- Multiple treatment placements

PH Intensive Residential Program

Peardonville House Treatment is a 70 day intensive residential treatment program designed for women who wish to stop the cycle of substance misuse in their life. The program is comprised of various components including: **1)** Education groups around topics such as relapse prevention, communication, feelings, families, co-dependency, self-esteem, problem-solving, goal-setting, parenting and healthy relationships. **2)** Individual and small group counselling. **3)** Access to mental health professionals and trauma counselling in the community. **4)** Yoga, sewing, meditation, beading and exercise. **5)** Art Therapy, Discovering your Authentic Self, All Nations Healing Circle, Personality Assessments, Connecting with WorkBC and Dog Therapy.

PH "Moms & Kids" Program

While mothers are attending the intensive residential program, their under school-aged children will be attending our full-time, licensed day care. Our daycare is bright and cheerful and offers many fun and educational activities for children including art, story time, dramatic play and daily outside play. All of our staff are trained Early Childhood Educators with many years of experience working with young children. Evening child care is also offered so mothers can attend meetings and work on their program. Our facility also offers a weekly parenting class covering many topics and dealing with issues of parenting young children. **Please note:** Children must be residing with client prior to treatment.

Please contact our intake and admissions coordinator if you have any questions at:

604-856-3966 extension 221 or intake@peardonvillehouse.ca

PEARDONVILLE HOUSE
TREATMENT CENTRE

The following information is required prior to a client being placed on our waiting list. ***Please ensure all information on these forms has been completed before sending. INCOMPLETE REFERRALS WILL NOT BE PROCESSED. Please email forms to intake@peardonvillehouse.ca or fax to 604-856-3960****. Thank you.*

GENERAL INFORMATION & STATS Date: _____

Client Name:	Other Names Used:	
Current Address :	City:	Postal Code:
Primary Telephone #:	Secondary Telephone #:	
S.I.N. #:	PHN#:	
Date of Birth:	Age:	Email:
Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Common Law ☐ Widow		
Employment Status: ☐ Employed ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed ☐ Not in labor force		
Ethnicity: ☐ Caucasian ☐ First Nations ☐ African ☐ Indo-Canadian ☐ Asian ☐ Other _____		
☐ Concurrent Disorder ☐ First Time Accessing Addiction Services ☐ IV Drug Use ☐ Methadone Maintenance		
Next of Kin to be Notified in Case of Emergency:		
Relationship:	Telephone #:	

REFFERRING AGENCY ASSESSMENT

Referring Agency Information:	
Case Manager's Name	Agency:
Agency Address	Email Address:
Telephone #:	**Fax #:**

WHICH PROGRAM ARE YOU REFERRING YOUR CLIENT TO?

Peardonville House:	☐ Moms & Kids	**Please do not use this referral for the Intensive program or Mollie's**

PEARDONVILLE HOUSE
TREATMENT CENTRE

How often have you seen this client? _____

Why would you like your client to attend treatment at this time? _____

_____

Please provide a brief explanation of the client's motivation and purpose in seeking treatment at Peardonville House. Include assessment of client's readiness for residential treatment.

_____

_____

_____

_____

Has your client been a resident at Peardonville House before? ☐ YES ☐ NO

If yes when? _____ Did she complete the program? ☐ YES ☐ NO

Is your client prepared to be admitted on 24 hour notice if space becomes available? ☐ YES ☐ NO

Will she have transportation and medications ready to go at a moment's notice? ☐ YES ☐ NO

Please explain your client's after care plan in terms of:

Housing:_____

Employment: _____

Education: _____

Childcare:_____

Support: _____

_____

_____

Does your client have an upcoming court date? ❑ YES ❑ NO

If yes, when?_____

Does your client have a no contact order? ❑ YES ❑ NO

If yes, with whom?_____

★*Please be aware that clients will* ***not be given permission to be absent from the program for court appearances****. Arrangements will need to be made prior to admission for court dates to be re-scheduled.*

PEARDONVILLE HOUSE
TREATMENT CENTRE

FUNDING INFORMATION

Please indicate below how treatment is to be financed.

☐ **MHSD:** If client is on Income Assistance, please have MHSD fill out the funding verification form on page 6 of the referral package. Client can take into the office to have it stamped or it can be faxed to their local Income Assistance office.

- **If the client receives any additional monies, (CPP, spousal support, etc,) MHSD will expect that money to be contributed toward the client's stay at Peardonville House.**
- **Clients will only receive $95 per month (unless on PWD/Disability) for comfort money and a partial contribution to their rent. Please check with MHSD regarding how much rent money they will pay.**

☐ **SELF-PAY:** $45 per day/person. Payment by Visa, Mastercard, cash, bank draft or Email Transfer is due prior to admission. (See methadone information below)

- If you would like to use a credit card, there will be a 3.5% processing fee
- There will be a 10% Administration fee (min $100) for all self-discharges
- The intake coordinator may set up a payment plan once an intake date is arranged.

☐ **BAND:** Full payment & a certificate of subsidization from Medical Services of Health & Welfare must be received prior to admission. (See methadone information below)

- If the client is a First Nations woman with status, she may apply to her band for funding or apply to:

  First Nations Health Authority
  501-100 Park Royal Avenue, Vancouver, BC, V7T 1A2
  Tel: 1-866-913-0033 Fax: 604-913-2081

☐ **EXTENDED HEALTH BENEFITS:** Please attach a confirmation letter from the insurance company prior to admission stating that treatment will be paid in full. (Including methadone clinic fees)

☐ **ACCOMMODATION SUBSIDY** - Clients may apply to their Health Authority through their Case Manager for an accommodation fee subsidy for partial or full payment.

- Please attach the relevant Health Authority Accommodation Fee Subsidy Approval form.
- The partial payment the client is responsible for is due upon admission unless otherwise indicated by the intake coordinator.
- Ensure you also apply for the child.

PEARDONVILLE HOUSE
TREATMENT CENTRE

FUNDING VERIFICATION FORM – MHSD

Client Name: _____

Phone: _____

SIN: _____ D.O.B _____

Referring Agent: _____Phone: _____

Fax:_____

The above named client has been referred for admission to a qualifying residential addictions program, Peardonville House Treatment Center. Prior to admission, the facility requires confirmation that the client's per diem costs (less and non-exempt income) will be paid by the MHSD (Ministry of Housing and Social Development) while in receipt of, and eligible for, Income Assistance.

Client Authorization:
I, _____, authorize the Ministry of Housing and Social Development to confirm my eligibility for funding, and to release and related information to my referring agent with the knowledge that this information will be released to Peardonville House.

Client Signature: _____ Date: _____

MINISTRY OF HOUSING OF SOCIAL DEVELOPMENT:
PLEASE COMPLETE & FAX TO ABOVE NUMBER

GA # _____

Client has an open/active file ☐ YES ☐ NO

Client funding eligibility ☐ Eligible ☐ Ineligible

Client's per diem will be paid by the MHSD as per current eligibility less non-exempt income.
Please make note of any non-exempt monthly income.

Non-exempt income from: _____

MHSD Per Diem amount for Client: _____

Child on file? _____ _____

Completed by: _____

Signature: _____

Date: _____

MINISTRY OFFICE STAMP

PEARDONVILLE HOUSE
TREATMENT CENTRE

Early Exit Transition Plan

The following plan will be put in place **if I leave early** from the Peardonville House Treatment Centre. It is understood that if I leave the program on short notice or if I do not arrive for my scheduled intake, my referral liaison and/or my early/emergency contact will be notified. I must also have a plan in place for shelter and transport prior to admission. **Please note clients who leave the program early have 30 minutes to be off-property and remaining clients will be debriefed.**

Client Name:	Date of Birth:
Destination upon early exit:	Address:
Transportation Plan and cost:	

Community Contact for Early Exit Support:

My emergency contact will also be contacted if I need to stay overnight at the hospital.

Name of Contact for Early Exit Plan:	Telephone # _____ Email address: _____
Name of Emergency Contact:	Telephone #: _____ Email address: _____

I agree that I am responsible for all transportation costs and that I am responsible for knowing the fees associated with bus, cab and/or ferry. I must have these funds available to me upon intake.

Client Signature:	Date:

SUBSTANCE ABUSE HISTORY

Please complete the following with the client:

Substance	Method of Use	Amount	Frequency	Age of First Use	Date of Last Use
Alcohol					
Amphetamines					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Crack					
Crystal Meth					
Ecstasy					
Fentanyl					
Hallucinogens					
Heroin					
Illicit Methadone					
Illicit use of Rx medications					
Inhalants					
Nicotine					
Opiates other than Heroin/methadone					
Club drugs • Ketamine • GHB • Rohipnol					

Drug of Choice: **1st:** _____

2nd: _____

3rd: _____

Eating Disorders: ☐ Current ☐ Past: How long ago? _____

Have you ever been hospitalized as a result of your eating disorder? ☐No ☐ Yes: When? _____

Please explain: _____

Please include an eating action plan for while you are in treatment that will allow staff to support you.

PEARDONVILLE HOUSE
TREATMENT CENTRE

MENTAL HEALTH INFORMATION

Does the client have a history of mental illness?	☐ YES	☐ NO
Is the client mentally stable with no current psychiatric concerns?	☐ YES	☐ NO

★If the client answers yes to the questions below, please attach the client's safety plan to this referral package ★

Is the client actively suicidal?	☐ YES	☐ NO
Has the client been suicidal in the past three months?	☐ YES	☐ NO
Does the client have a history of self-harm?	☐ YES	☐ NO
Has the client been hospitalized in the last 30 days?	☐ YES	☐ NO

If yes, for what reason? _____

What mental health conditions has the client been treated for by a mental health professional or physician during her lifetime?

☐ Depression	☐ Sleep Disorder	☐ Substance-Related Disorder
☐ Schizophrenia	☐ Self Injury	☐ Conduct Disorder
☐ Bi-Polar	☐ Psychosis	☐ Dissociative Disorder
☐ Anxiety	☐ Impulse Control	☐ Borderline Personality Disorder
☐ PTSD	☐ Other _____	

Have you experienced a traumatic event? If so, please explain: _____

_____

Please provide additional information for mental health conditions such as: date of official diagnosis, treatment, current mental health stability, first and last incidence of symptoms, etc.

_____

_____

Professionals currently involved in client's mental health treatment:

Name	Professional Designation	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that the program is a full 10 weeks and it is mandatory to attend and participate all aspects of programming. It is the client's responsibility to keep in contact with Peardonville House (604-856-3966) after they have been placed on the wait list to indicate continued interest in treatment. Failure to do so will result in the client being considered "inactive" and not contacted for available placements.

_____	_____
Client's Signature	Referring Agent's Signature

PEARDONVILLE HOUSE
TREATMENT CENTRE

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN OR N.P.

MEDICAL INFORMATION

The House Physician at Peardonville House will attend to the client's needs while she is in residence. Peardonville House is not responsible for the client's other health care needs such as dental care, physiotherapy, eyeglasses, etc. If any of these problems need attention they need to be addressed before entry into the program.

A note from a public health nurse or doctor is required from all residents stating that they are free of head lice and scabies. This note may be faxed prior to admission or submitted upon arrival.

Physician's Name: _____	Phone Number _____
Methadone Doctor's Name: _____	Phone Number _____
Psychiatrist's Name: _____	Phone Number _____

Does your client have any previous or current medical concerns? (e.g. High blood pressure, diabetes, heart disease, history of seizures, stroke, etc.) **Any special food requirements (e.g. Celiac disease/vegetarian)?** If yes, please explain:_____

_____

_____**Please note: if food allergies/food requirements are not noted clients will not be given special dietary consideration.**

Does your client have special health care needs? (Mobility issues, walking stairs, bending, sitting, doing chores, etc.)? If yes please explain:_____

_____

Does your client need regular blood work? ☐ YES If yes how often? _____

Does your client have any allergies? ☐ YES ❑ NO

If yes, please list: _____

Is your client pregnant? ☐ YES ❑ NO If yes, what is the expected due date? _____

✶ **Please note that we will not accept any clients in their last trimester**

If yes, has the client satisfied all prenatal medical expectations? ☐ YES ❑ NO

Is the client on OAT? ☐ YES ❑ NO Please indicate what OAT client is taking: _____

If yes, please indicate: a) Current dose _____ml b) Length of time on dose: _____ Months/Years

✶If yes, incoming clients must arrange at least 3 weeks of methadone prescriptions to be brought upon arrival. Client must be stabilized on this dose for at least three months.

PEARDONVILLE HOUSE
TREATMENT CENTRE

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN OR N.P.

Patient Name: _____

D.O.B. _____ PHN: _____

Status #: _____

Weight: _____ Height: _____

Drug Allergies: _____

List all medications your patient is currently taking:

Medications:	Strength: mg/ml	Condition:	Time Med is Taken:

★**Peardonville House does not accept clients currently on opiates, benzodiazepines or other addictive medications. It is best if clients attend detox or have their opiates and/or benzodiazepines tapered under the care of their physician prior to admission to Peardonville House.**

Recommended Immunizations

Immunization Name	**Yes**	**No**	**Unknown**	**Frequency of Booster**
Tetanus & Diphtheria (Td)				Date of last booster: _____
Measles (required if born after 1956)				None
Rubella (MMR)				None
Mumps (MMR)(required if born after 1956)				None
Influenza				Date of last immunization: _____
Pneumococcal				None
Hepatitis B				None

PEARDONVILLE HOUSE
TREATMENT CENTRE

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN OR N.P.

Please indicate whether the client is able to have the following prescriptions by placing your initials next to the meds she may have while in treatment.

Standing Order Medication Form **Client Name:** _____

Indication	Medication and Guidelines	YES	NO
Pain & fever or inflammation	Ibuprofen 200mg – 1-2 tabs every 4-6 hrs to a maximum of three times per day **And/Or** Acetaminophen 500mg 1-2 tabs every 4-6 hrs to a maximum of four times a day (4000mg). If client is taking any prescribed anti-inflammatories (e.g. Naproxen, Ketorolac (Toradol) etc., **do not** give Ibuprofen).		
Cough and/or Congestion	Ice Water		
Hayfever	Loratadine 10mg (ex. Claritin) max 1 tab every 24hrs		
Hives or itchy rash	Diphenhydramine 25mg (ex. Benadryl) 1-2 tabs every 6 hrs as needed, max 200mg/24 hours		
Toothache	Insert cotton ball soaked in clove oil into tooth cavity		
Diarrhea	Loperamide 2mg (ex. Imodium) 2 tabs for first dose, then 1 tab after each bowel movement, max 8 tabs/24hrs		
Nausea and/or vomiting	Dimenhydrinate (ex. Gravol) 100mg rectal suppository 1 supp every 6-8 hrs max 300mg/24 hrs		
Heartburn/indigestion	Magnesium/Aluminum suspension antacid (ex. Gaviscon liquid) 10-20 mls (2-4 tsp) up to the maximum of 80mls (16tsp) per 24 hours		
Severe allergic reaction with swelling of lips, face, neck and throat, wheezing and difficulty breathing	**Epi-Pen (Pre-filled epinephrine syringe) injected into thigh 1x** **AND call 911 immediately**		
Bowel Protocol *	Encourage all clients to increase dietary fibre, increase fluid intake and increase exercise.		
Constipation Day 1	Clearlax 17gr (to top of inner white lid) mix in 250ml liquid 1x/day for 7 days		
Constipation Day 2	Continue above		
Constipation Day 3	Consider glycerin suppository rectally 1x/day		
Constipation Day 4	Combination tablet of Senna Laxative (8.6mg) & Docusate Sodium (50mg) 2-4 tabs 1-2 times daily for 7 days		
Constipation Day 5	Please notify physician or nurse practitioner		

Physician's signature: _____ CPSID#: _____

Client signature: _____ Date: _____

PEARDONVILLE HOUSE
TREATMENT CENTRE

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN OR N.P.

MEDICATION AUTHORIZATION SHEET - CHILDREN

Indication	Medication and	Guidelines
Fever/Pain	Acetaminophen - liquid **OR**	SEE DOSAGE CHART Every 4 – 6 hours DO NOT EXCEED 5 DOSES PER 24 hours
Fever/Pain	Ibuprofen - liquid **Acetaminophen should be first choice**	SEE DOSAGE CHART Every 6 – 8 hours DO NOT EXCEED 4 DOSES PER 24 hours

Dosage Chart:

Child's Weight:	Infant's Acetaminophen	Children's Acetaminophen	Infant's Ibuprofen	Children's Ibuprofen
12-17 lbs	1mL		1ml	
18-23 lbs	1.5mL		1.4ml	
24-35 lbs		5mL	3 ml	6 mls
36-47 lbs		7.5mL		10 mls

Fever Chart:	**Oral: over 37.5**	**Armpit (auxiliary temp): over 37.4**

Medication Release – Children

Name of Child: _____

Weight: _____ Age: _____

DOB: _____PHN:_____

_____ _____

Doctor's signature Date

I hereby give my permission for the provider, ***Peardonville House Treatment Centre,*** to administer this medication to my child according to the prescribed instructions.

_____ _____

Parent's signature Date

PEARDONVILLE HOUSE
TREATMENT CENTRE

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN OR N.P.

Patient Name: _____

Child's Name: _____

I, Dr. _____ have thoroughly checked the above patient(s) and have found no evidence of Head Lice or Scabies.

Date: _____

Signature: _____

PEARDONVILLE HOUSE
TREATMENT CENTRE

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN OR N.P.

PRESCRIPTION

- **Peardonville House is not licensed to administer medication brought into treatment by the client**
- Please write out all orders (excluding Methadone/Suboxone) **for a 3-month supply for your patient including OTC medications and vitamins**. WE DO NOT ACCEPT BENZODIAZAPINES, NARCOTICS, OPIATES OR STIMULANTS**.** Peardonville will fill the prescription for the client on arrival.
- Please fax to 604-856-3120 and forward all original triplicate prescriptions to:

Peardonville House Treatment Center, 825 Peardonville Road, Abbotsford, BC V4X 2L8

Extended Health Benefits Information

Carrier: _____ Carrier #:_____

Plan #: _____ Member ID#: _____

Name of Plan Holder: _____

PLEASE PRINT CLEARLY – if not prescribing any medications, please indicate N/A - this page is required by our pharmacy for every client

Please handwrite "DAILY DISPENSE" on the prescription below:

Rx

Client Name: _____

Date: _____

Daily Dispense for all

Can Have Weekend & Holiday Carry on Patient Request. May Dispense 1 Week of Medication on Discharge

PEARDONVILLE HOUSE
TREATMENT CENTRE

BRITISH COLUMBIA
Ministry of Health

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act,* S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, _____, authorize Colleen Regehr (NP)
Name of Patient (print)

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

Executed at _____, this _____ day of _____, 20_____.

SIGNED AND DELIVERED by)

_____)
Patient (print))

in the presence of:)

_____) _____
Witness (signature)) ***Patient (signature)***

_____)
Witness (print))

_____)
(Dated))

PEARDONVILLE HOUSE
TREATMENT CENTRE

CLIENT INFORMED CONSENT AND RELEASE

DRUG AND ALCOHOL TESTING

I, _____, consent to allow Peardonville House Treatment Centre (***PHTC***) to collect urine specimens or swabs from me for testing for mood altering substances. I also give my consent for the release of the test results to ***PHTC*** and its physician and/or Nurse Practitioner.

I further authorize and give full permission to have ***PHTC*** and/or its physician and/or Nurse Practitioner to send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to ***PHTC***. I further agree to and hereby authorize the release of the results of said tests to ***PHTC*** and its Physician and/or Nurse Practitioner.

I further agree to hold harmless ***PHTC*** and its physician and/or Nurse Practitioner from any liability arising in whole or part, out of the collection of specimens, testing, and use of the information from said testing in connection with ***PHTC's*** consideration of my participation in the Intensisve/Mom and Kids/Mollies programs.

APPLICANT:

Print Name: _____ PHN #: _____

Signature: _____ Date: _____

WITNESS:

Print Name: _____

Signature: _____

CONSENT FORM

Description	Name	Phone	Fax & Email
Addictions Counselor			
Physician			
Psychiatrist			
Probation/ Parole Officer			
Social Worker			
Other:			
Other:			

Additional Comments:

My signature indicates that I give permission for my counselor and/or the manager in the counsellor's absence to release information to the professionals indicated above. Information to be released includes, but is not restricted to the following: attendance, treatment plan summary, drug test results, general progress, and any other information.

_____ _____

Client Signature Counselor Signature

_____ _____

Client Name Date

PEARDONVILLE HOUSE
TREATMENT CENTRE

Request for Temporary Placement for Child at Peardonville House

If you are seeking admission to the Mom's and Kids Program, please complete the following 2 pages and send to Peardonville House. Be advised that children accepted into the program must be between the ages of three months and six years and not enrolled in school. Maximum of two children will be accepted.

Child Assessment:

Child's Name: _____

DOB: _____Age: _____

Child's Medical Number (PHN): _____

Child's Physician's name: _____

Child's Dentist's Name:

Did Mother use alcohol or drugs during pregnancy? ☐ YES ☐ NO

If yes, please provide a description of what drug(s) and the duration of use: _____

_____

Is the child being treated for an illness or have any known allergies? ☐ YES ☐ NO

If yes, please explain: _____

_____

Please list the name of anyone who has LEGAL access to the child. Please include a copy of the legal order and a letter for the Social Worker if there are any concerns. _____

_____

_____

_____

_____

_____

Has the child been or is currently in foster care? ☐ YES ☐ NO

If yes, please list the Foster Parent's information:

Foster Parent's Name: _____

Foster Parent's Phone number: _____

If yes, please record how long the child has been or was in care and the circumstances regarding apprehension and care agreement. _____

_____

_____

_____

Has the child been involved in daycare or a similar setting?

Daycare Name: _____

Daycare Phone number: _____Location: _____

Is there anything else you feel Peardonville House needs to be aware of about your child?

_____

_____

_____

_____

_____

_____

_____

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Appendix I

Exemption Request Forms

Client Name	DoB*(dd/mm/yy)*	Age
Child(ren)'s Name(s)	DoB*(dd/mm/yy)*	Age
1.		
2.		

Section 1 - To be Completed by Client:

Client Confirms:

- ❑ I am the legal guardian of the above-mentioned child(ren).
  - ❑ I have sole custody of the above-mentioned child(ren).
  - ❑ Another adult has joint guardianship and/or joint custody of the above-mentioned child(ren). Please specify:

    _____
    _____
    _____

  - ❑ A letter of support is attached from joint guardian/custodial parent for child placement in Peardonville House Treatment Centre.
- ❑ I believe it is in the best interest of my child(ren) to live with me at Peardonville House Treatment Centre while I participate in residential treatment for substance misuse.
- ❑ I am capable and willing to care for my child(ren) during the hours I am not in program and the children are not in daycare (mealtimes, overnight, mornings, weekends).
- ❑ If I become unable to care for my child(ren), I authorize Peardonville House Treatment Centre staff to contact and release my child(ren) into the care of my Emergency Contacts:

_____ _____
Name of Emergency Contact (#1) Relationship to Child

_____ _____
Address *(include city & postal code)* Phone # *(with area code)*

_____ _____
Name of Emergency Contact (#2) Relationship to Child

_____ _____
Address *(include city & postal code)* Phone # *(with area code)*

Client Name	DoB*(dd/mm/yy)*	Age
Child(ren)'s Name(s)	DoB*(dd/mm/yy)*	Age
1.		
2.		

Section 1 (Continued) - This Portion to be Completed by Client:

- ❑ I acknowledge that if my Emergency Contact is not available within 24 hours that the Ministry of Children and Family Development will be contacted (310-1234) to care for my child(ren).
- ❑ I support that while I am in program my child(ren) will be attending a group daycare program for children who are at least 3 months of age and have not entered Grade 1.
- ❑ I give permission for the Ministry of Children & Families Development to provide information on the status of my child(ren) related to "care" (only for Protection Cases).

_____ _____

Client Signature Date Signed *(dd/mm/yy)*

fraserhealth

Appendix I
Exemption Request Forms

Client Name	DoB*(dd/mm/yy)*	Age
Child(ren)'s Name(s)	DoB*(dd/mm/yy)*	Age
1.		
2.		

Section 2 - To be Completed by a MCFD social worker and/or the referring worker

Access
Please comment on the current relationship between the mother and child(ren).

_____

_____

How much access does the mother have to her child(ren) currently?

_____

_____

- ❑ Client is capable of caring for her child(ren) when she is not in program and the child(ren) are not in daycare (mealtimes, overnight, mornings, weekends).
- ❑ It is in the best interest of the client's child(ren) to be temporarily placed at Peardonville House Treatment Centre with their mother
- ❑ I support that the client's child(ren) will be attending a group daycare program for children who are at least 3 months of age and have not entered Grade 1.

The MCFD social worker and/or referring worker commits to establishing close communication with Peardonville House and providing necessary information.

If Client File is designated **PROTECTION**, please tick the appropriate boxes:

- ❑ The child(ren) is/are NOT in the care of the Ministry for Children & Families Development (MCFD**). Children in the care of MCFD cannot be placed in Peardonville House.**
- ❑ The referred client is the legal guardian and custodial parent of the child(ren) listed above.
- ❑ There is a supervision order or court order in place with terms. It is attached to this request and Peardonville House Treatment Centre is aware.
- ❑ MCFD is in the process of applying for a supervision order, proposed terms are attached.
- ❑ There is no supervision order in place. The child(ren)'s mother has entered the Peardonville House Treatment Centre program voluntarily, yet the file remains designated PROTECTION.
- ❑ Emergency contact reviewed with mother.
- ❑ Other, please specify:

_____

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Appendix I
Exemption Request Forms

Client Name	DoB*(dd/mm/yy)*	Age
Child(ren)'s Name(s)	DoB*(dd/mm/yy)*	Age
1.		
2.		

Section 2 (Cont.) - To be Completed by a MCFD social worker and/or the referring worker

If Client File is designated **NON-PROTECTION**, the appropriate boxes must be ticked:

- ❑ MCFD will be maintaining an open file to support the family on a voluntary basis.
- ❑ MCFD will be closing the file.
- ❑ There is no MCFD involvement.
- ❑ Other, please specify: _____

❑ I have read and understand the Protocol between Peardonville House Treatment Centre, MCFD, and Fraser Health.

MCFD Social Worker's Signature — Date Signed *(dd/mm/yy)*

MCFD Social Worker's Name *(Please Print)* — Phone # *(with Area Code)*

MCFD Social Worker's Email Address *(Please Print)* — Fax # (*with Area Code*)

❑ I have read and understand the Protocol between Peardonville House Treatment Centre, MCFD and Fraser Health.

Referring Worker's Signature — Date Signed *(dd/mm/yy)*

Referring Worker's Name *(Please Print)* — Phone # *(with Area Code)*

Referring Worker's Email Address (*Please Print)* — Fax # *(with Area Code)*

HONOS ASSESSMENT (Health of the Nation Outcome Scales)

Name: _____

1. **Rate** each scale in order from 1 to 12
2. **Do not** include information rated in an earlier item except for item 10 which is an overall rating
3. **Rate** the MOST SEVERE problem that occurred during the 2 weeks prior to this rating.

1. Overactive, aggressive, disruptive or agitated behavior - Include behavior due to drugs, alcohol, dementia, psychosis, depression, etc. Do not include bizarre behavior, rated at Scale 6

0 No problems of this kind during the period rated

1 Irritability, quarrels, restlessness etc. not requiring action

2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked agitation

3 Physically aggressive to others or animals; destruction of property, threatening manner;

4 At least one serious physical attack on others or on animals; destruction of property (e.g. fire-setting); serious intimidation or obscene behavior

Comment: _____

2. Non-accidental self-injury

0 No problems of this kind during the period rated

1 Fleeting thoughts about ending it all but little risk; no self-harm

2 Mild risk during the period; includes non-hazardous self-harm, e.g. wrist-scratching

3 Moderate to serious risk of deliberate self-harm, including preparatory acts- collecting tablets

4 Serious suicidal attempt and/or serious deliberate self-injury

Comment: _____

3. Problem-drinking or drug-taking:

0 No problems of this kind during the period rated

1 Some over-indulgence but within social norm

2 Loss of control of drinking or drug-taking, but not seriously addicted

3 Marked craving or dependence on alcohol or drugs with frequent loss of control, risk taking under the influence, etc.

4 Incapacitated by alcohol/drug problems

Comment: _____

4. Cognitive problems: Include problems of memory & understanding associated with any disorder; learning disability, dementia, schizophrenia, etc.

0 No problems of this kind during the period rated

1 Minor problems with memory or understanding, e.g. forgets names occasionally

2 Mild but definite problems e.g. has lost the way in a familiar place or failed to recognize a familiar person; sometimes mixed up about simple decisions

3 Marked disorientation in time, place or person, bewildered by everyday events; speech is sometimes incoherent; mental slowing

4 Severe disorientation e.g. unable to recognize familiar faces, speech incomprehensible

Comment: _____

5. Physical illness or disability problems: Include illness or disability from any cause. Include side-effects from medication; effects of drug/alcohol use; physical disabilities

0	No physical health problem during the period rated
1	Minor health problem during the period (e.g. cold, non-serious fall, etc.)
2	Physical health problem imposes mild restriction on mobility and activity
3	Moderate degree of restriction on activity due to physical health problem
4	Severe or complete incapacity due to physical health problem

Comment: _____

6. Problems associated with hallucinations and delusions irrespective of diagnosis
Include odd and bizarre behavior associated with hallucinations or delusions

0 No evidence of hallucinations or delusions during the period rated

1 Somewhat odd or eccentric beliefs not in keeping with cultural norms

2 Delusions of hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behavior, i.e. clinically present but mild.

3 Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behavior, i.e. moderately severe clinical problem

4 Mental state and behavior is seriously and adversely affected by delusions or hallucinations, with severe impact on patient

Comment: _____

7. Problems with depressed mood

0 No problems associated with depressed mood during the period rated

1 Gloomy; or minor changes in mood

2 Mild but definite depression and distress: e.g. feelings of guilt; loss of self-esteem

3 Depression with inappropriate self-blame, preoccupied with feelings of guilt

4 Severe or very severe depression, with guilt of self-accusation

Comment: _____

8. Other mental and behavioral problems: Specify the type of problem by circling the appropriate letter both here and on the score sheet: A phobic; B anxiety; C obsessive-compulsive; D stress; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify

0 No evidence of any of these problems during period rated

1 Minor non-clinical problems

2 A problem is clinically present at a mild level, e/g patient/client has a degree of control

3 Moderately severe level of problem; Occasional severe attack or distress, with loss of control

4 Severe problem dominates most activities

Comment: _____

9. Problems with relationships: Rate most severe problem associated with active or passive withdrawal from social relationships and/or non-supportive, destructive or self-damaging relationships

0 No significant problems during the period

1 Minor non-clinical problem

2 Definite problems in making or sustaining supportive relationships; evident to others

3 Persisting major problems due to active or passive withdrawal form social relationships, and/or relationships that provide little or no comfort or support

4 Severe and distressing social isolation and/or withdrawal from social relationships

Comment: _____

10. Problems with activities of daily living: e.g**.** eating, washing, dressing, toilet; complex skills - budgeting, finding housing, recreation, use of transport, shopping, etc. Include any lack of motivation for using self-help opportunities as this contributes to a lower overall level of functioning.

0 No problems during the period rated; good ability to function in all areas

1 Minor problems only: e.g. untidy, disorganized

2 Self-care adequate but major lack of performance of one or more complex skills (see above)

3 Major problems in one or more area of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills

4 Severe disability or incapacity in all or nearly all areas of self-care and complex skills

Comment: _____

11. Problems with living conditions and daily domestic routine: Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and opportunities to use intact skills and develop new ones?

0 Accommodation and living conditions are acceptable;

1 Accommodation is reasonably acceptable although there are minor problems

2 Significant problems with one or more aspects of the accommodation

3 Distressing multiple problems with accommodation; e.g. some basic necessities absent; housing environment has minimal or no facilities to improve patient's independence

4 Accommodation is unacceptable:

Comment: _____

12. Problems with occupation, activities in daytime environment. Is there help to cope with disabilities? Are there opportunities to maintain/improve skills and activities? Consider stigma, access to supportive facilities and qualified staff.

0 Patient's day-time environment is acceptable and supportive of self-help

1 Minor or temporary problems requiring little action e.g. late cheques; reasonable facilities available but not always at desired times, etc.

2 Limited choice of activities – lack of permanent address or insufficient career or professional support; helpful day setting available but for very limited hours

3 Marked deficiency in skilled services available to help minimize level of existing disability; no opportunities to use intact skills or add new ones;

4 Lack of opportunity for daytime activities makes patient's problems worse

Comment: _____

HONOS Score Sheet			
	Rate 9 if not known		**Rate**
1	Overactive, aggressive, disruptive behavior	**0 1 2 3 4**	
2	Non-accidental self-injury	**0 1 2 3 4**	
3	Problem-drinking or drug-taking	**0 1 2 3 4**	
4	Cognitive problems	**0 1 2 3 4**	
5	Physical illness or disability problems	**0 1 2 3 4**	
6	Problems with hallucinations and delusions	**0 1 2 3 4**	
7	Problems with depressed mood	**0 1 2 3 4**	
(Specify disorder A,B,C,D,E,F,G,H,I, or J)			
8	Other mental & behavioral problems	**0 1 2 3 4**	
9	Problems with relationships	**0 1 2 3 4**	
10	Problems with activities of daily living	**0 1 2 3 4**	
11	Problems with living conditions	**0 1 2 3 4**	
12	Problems with occupation and activities	**0 1 2 3 4**	

GAIN ASSESSMENT Date: _____

Name: a._____ b._____ Age: _____
(First name) (Last Name)

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for **two or more weeks**, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following statements, please tell us the last time you had this problem, if ever, by circling the appropriate corresponding number.

	Past month	2 to 12 months ago	1 + years ago	Never
	3	2	1	0
1. When was the last time you had significant problems…				
a. With feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	3	2	1	0
b. With sleeping, such as bad dreams, sleeping restlessly or falling asleep during the day?	3	2	1	0
c. With feeling very anxious, nervous, tense, fearful, scared, panicked or like something bad was going to happen?	3	2	1	0
d. When something reminded you of the past and you became very distressed and upset?	3	2	1	0
e. With thinking about ending your life or committing suicide?	3	2	1	0
2. When was the last time you did the following things two or more times?				
a. Lied or conned to get things you wanted or to avoid have to do something?	3	2	1	0
b. Had a hard time paying attention at school, work or home?	3	2	1	0
c. Had a hard time listening to instructions at school, work or home?	3	2	1	0
d. Were a bully or threatened other people?	3	2	1	
e. Started fights with other people?	3	2	1	0
3. When was the last time…				
a. You used alcohol or drugs weekly?	3	2	1	0
b. You spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high or sick)?	3	2	1	0
c. You kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	3	2	1	0
d. Your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?	3	2	1	0
e. You had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems?	3	2	1	0
4. When was the last time you….				
a. Had a disagreement in which you pushed, grabbed or shoved someone?	3	2	1	0
b. Took something from a store without paying for it?	3	2	1	0
c. Sold, distributed or helped to make illegal drugs?	3	2	1	0
d. Drove a vehicle while under the influence of alcohol or illegal drugs?	3	2	1	0
e. Purposely damaged or destroyed property that did not belong to you?	3	2	1	0
5. Do you have other significant psychological, behavioral or personal problems you want treatment for or help with?	Yes		No	

If yes, please describe: _____

PEARDONVILLE HOUSE
TREATMENT CENTRE

~Please give this list to your client in order to prepare for intake~

Client Checklist of What to Bring:

- ☐ Alcohol free personal hygiene products (shampoo, soap, toothbrush, etc.)
- ☐ Feminine products (tampons, pads)
- ☐ Comfortable and appropriate clothing and footwear *including flip flops to wear in the shower*
- ☐ Facecloths
- ☐ Personal identification (necessary for payment)
- ☐ 3 weeks of methadone prescription where applicable
- ☐ Alarm clock
- ☐ Clear water container
- ☐ Binder, pens, journal, lined paper
- ☐ Local or Long-distance payphone card (**VOX** brand)
- ☐ Loonies and quarters for laundry ($2.25 per load)
- ☐ Umbrella and raincoat and stroller cover for walks in the rain
- ☐ **Tobacco products for a minimum of 3 weeks (no loose tobacco/rolling papers)**
- ☐ **SEPTIC SAFE Laundry soap (e.g. TIDE)** and dryer sheets
- ☐ **$20.00 linen deposit to be handed in on intake**

Mom's checklist of what to bring

- ☐ **Mother photo I.D. & Child's Identification (copy needed before intake!!) ****
- ☐ **Diapers, pull ups, formula and baby wipes for a minimum of 3 weeks**
- ☐ Child's immunization record
- ☐ Your child's favorite toys (maximum of 3 – please no stuffed animals or blankets)

What not to bring

- ☐ No electronics : Cellphones, MP3 players, iPods, laptops
  - No E-cigarettes/Vaporizers
  - Movies/DVDs/CDs, Personal gaming devices
  - Televisions/stereo equipment etc.
- ☐ Food or drink of any kind, including gum (this includes Nicorette)
- ☐ Live plants
- ☐ Stuffed animals/bedding/towels *** **No exceptions*****
- ☐ Valuables or breakables
- ☐ Provocative/inappropriate clothing or reading materials - No high heels
- ☐ No perfume, body spray or heavily scented lotions (we are a scent-free zone)
- ☐ Aerosol sprays
- ☐ Nail polish or nail polish remover
- ☐ No prescription meds or over-the-counter medications – this includes vitamins and creams
- ☐ **We are on a septic system so must be careful about what goes down the drain. Therefore no:**
  - Products with bleach or fabric softener
  - Hair Dye
  - Bath salts

REMINDERS:

- ☐ Clients may not be on benzodiazepines, opiates, narcotics, muscle relaxants or stimulants
- ☐ Clients will be on phone/visit restrictions until the 15th day of their stay
- ☐ Clients will not receive a day pass until the weekend after their 21st day.

Due to space restrictions and bed bug protocols, clients are limited to one suitcase (Max 27 inches and 50lb) per person and one small handbag only. Any additional belongings will be sent home upon arrival. Belongings will be searched upon arrival and all unsafe products will be removed and put in storage until the client completes the program.