

## Peardonville House Mom & Kids Program Referral Package

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](mailto:intake@peardonvillehouse.ca) or fax to 604-856-3960.

Date: \_\_\_\_\_

### GENERAL INFORMATION & STATS

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

### REFERRING AGENCY ASSESSMENT:

<b>Referring Agency Information:</b>	
Case Managers Name:	Agency:
Agency Address:	Email Address:
Telephone #:	Fax #:

### WHICH PROGRAM ARE YOU REFERRING YOUR CLIENT TO?

Peardonville House Treatment Centre: <input type="checkbox"/> Moms & Kids
<b>Do not use this referral package for the Intensive or Mollie's program.</b>

What is the nature of your relationship with this client?

---

---

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 and what program? \_\_\_\_\_

Did they complete the program?  Yes  No

Is your client prepared to be admitted on 24-hour notice if space becomes available?  Yes  No

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

Housing: \_\_\_\_\_

Employment: \_\_\_\_\_

Education: \_\_\_\_\_

Childcare: \_\_\_\_\_

Support System: \_\_\_\_\_

Does your client have any upcoming court dates?  Yes  No

If yes, when? \_\_\_\_\_

Does your client have any court orders in place we need be aware of?  Yes  No

If yes, please provide more information:

---

***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.***

## 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 money, (CPP, spousal support, etc.) MHSD expects 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.
- 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.



## 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 Poverty Reduction 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 Poverty Reduction.

Client Full Name		
Phone Number	Date of Birth	SIN Number

I hereby authorize the staff from the Ministry of Social Development and Poverty Reduction 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.

### 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: _____
Name of Emergency Contact:	Telephone: _____ Email: _____

**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 Use 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)					
Club Drugs (Ketamine, GHB, Rohypnol)					

### Drug of Choice:

1<sup>st</sup>: \_\_\_\_\_

2<sup>nd</sup>: \_\_\_\_\_

3<sup>rd</sup>: \_\_\_\_\_

### Relationship with Food:

Does the client have history with disordered eating?  Yes  No (if "No", skip this section)

Current

Past; How long ago? \_\_\_\_\_

Has the client ever been hospitalized due to an eating disorder?  Yes  No

If "Yes", provide more information:

\_\_\_\_\_

**\*Please note that Peardonville House is unable to support clients with current acute eating disorders. We require medical clearance from ED team supporting client prior to intake.**

## Mental Health Information

Does the client have a history of mental illness?  Yes  No

Is the client's mental health in a place of stability to attend residential treatment?  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 expressed suicidal intent 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 have the client been treated for by a mental health professional or physician during their lifetime?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Sleep Disorder  | <input type="checkbox"/> Substance-Related Disorder      |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Self-injury     | <input type="checkbox"/> Conduct Disorder                |
| <input type="checkbox"/> Bipolar       | <input type="checkbox"/> Psychosis       | <input type="checkbox"/> Dissociative Disorder           |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Impulse Control | <input type="checkbox"/> Borderline Personality Disorder |
| <input type="checkbox"/> PTSD          | <input type="checkbox"/> Other: _____    |  |

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 Signature

\_\_\_\_\_  
Referring Agents Signature

## 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 them to Intake.

Be advised that children accepted into the program must be under six years of age (and not enrolled in school). Due to space considerations, an adult entering the Mom's and Kids program is able to have a maximum of two children attend the program with them.

### Child Assessment:

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Child's Medical Number (PHN): \_\_\_\_\_

Child's Physician's Name: \_\_\_\_\_

Child's Dentist's Name: \_\_\_\_\_

Was the child exposed to substances in-utero during pregnancy?  Yes  No

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

Is the child currently being treated for an illness or face barriers due to a chronic condition?  Yes  No

If yes, please explain: \_\_\_\_\_

Does the child 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 if applicable.

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Has the child been placed in alternative care without the mother?  Yes  No

If yes, please explain, including how long the child has been outside of the mother's care:

---

---

---

Has the child been involved in daycare or a similar setting?  Yes  No

If yes, please fill below:

Daycare Name: \_\_\_\_\_

Daycare Phone Number: \_\_\_\_\_

Daycare Location: \_\_\_\_\_

Does the child have any identified learning challenges, or behavioural needs that program staff should be aware of?

---

---

---

---

---



Client Name	DOB (DD/MM/YYYY)	Age
Child(ren)'s Name(s)	DOB (DD/MM/YYYY)	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 programming 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 Number (with area code)

\_\_\_\_\_  
Name of Emergency Contact (2)

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Address (include city & postal code)

\_\_\_\_\_  
Phone Number (with area code)



**Appendix I**  
**Exemption Request Form**

<b>Client Name</b>	<b>DOB (DD/MM/YYYY)</b>	<b>Age</b>
<b>Child(ren)'s Name(s)</b>	<b>DOB (DD/MM/YYYY)</b>	<b>Age</b>
<b>1.</b>		
<b>2.</b>		

---

**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 the program my child(ren) will be attending Peardonville House's 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/YYYY)



Client Name	DOB (DD/MM/YYYY)	Age
Child(ren)'s Name(s)	DOB (DD/MM/YYYY)	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? \_\_\_\_\_

- The 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 Peardonville House's 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 the 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: \_\_\_\_\_



Client Name	DOB (DD/MM/YYYY)	Age
Child(ren)'s Name(s)	DOB (DD/MM/YYYY)	Age
1.		
2.		

**Section 2 (Continued) – 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, & Fraser Health.**

\_\_\_\_\_  
MCFD Social Worker's Signature

\_\_\_\_\_  
Date Signed (DD/MM/YYYY)

\_\_\_\_\_  
MCFD Social Worker's Name **(Please Print)**

\_\_\_\_\_  
Phone Number **(with Area Code)**

\_\_\_\_\_  
MCFD Social Worker's Email Address **(Please Print)**

\_\_\_\_\_  
Fax Number **(with Area Code)**

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

\_\_\_\_\_  
Referring Worker's Signature

\_\_\_\_\_  
Date Signed (DD/MM/YYYY)

\_\_\_\_\_  
Referring Worker's Name **(Please Print)**

\_\_\_\_\_  
Phone Number **(with Area Code)**

\_\_\_\_\_  
Referring Worker's Email Address **(Please Print)**

\_\_\_\_\_  
Fax Number **(with Area Code)**