Please PRINT this form and fax the completed copy to 604-524-4634

REFERRING AGENTS PLEASE NOTE:

Clients must have their name on the waitlist **before** we can accept a completed referral package from an agent.

A referral received without client on the waitlist will be held for 48 hours only.

INTAKE OFFICE – 24 hours/day, 7 days/week

Toll Free: 1-866-524-5633

Office: 604-524-5633

Fax: 604-524-4634

Once a client has been placed on the wait list, in order to maintain their position on the list the client must:

- Call everyday to check in with any Westminster House Staff. All check-ins are documented. If I client does not call in for 2 weeks they will be taken off the wait list.
- Funding confirmation in place
- Confirmation of TB testing
- Clients referral package filled out by a counsellor, Doctor, or Social Worker
  - Print the referral package
  - Fill out the referral package in detail
  - Sign the referral package
  - Fax the completed document to 604-524-4634
- All referral sources are considered

DAILY SCHEDULE

6:30 AM	-	Wake, make bed, dress
7:00 AM	-	Breakfast
7:40 AM	-	Leave for 12 step meeting
9:30 AM	-	Group process
12:30 PM	-	Lunch
Afternoon		Chores
		Appointments
		Recreation
5:30 PM	-	Dinner
Evening	-	12 Step Meeting
10:00 PM	-	Curfew
10:30 PM	-	Bed Time
11:00 PM	-	Lights Out

WESTMINSTER HOUSE REFERRAL FORM

The referral form information will be used to determine the client's suitability to the program. To make sure this client gets the best outcome from treatment, please complete the form as thorough as possible.

REFERRING AGENCY INFORMATION

Date ____________________

Referring Agent ____________________

Agency Address ____________________

City ____________________ Postal Code ____________________

Phone ____________________ Fax ____________________

Email ____________________

CLIENT INFORMATION

Is the client aware this is a non-smoking program? Yes ☐ No ☐

Name ____________________

Address ____________________

City ____________________ Postal Code ____________________

Phone ____________________ Other ____________________

Email ____________________ DOB ____________________

SIN ____________________ Medical # ____________________

Marital Status ____________________ Employment ____________________

Physician ____________________ Phone ____________________

Next of Kin ____________________ Phone ____________________

Is the client on any prescribed medications? Yes ☐ No ☐

Current Medications (attach MAR sheet where applicable):

____

____

____

Does the client have any eating disorders? Yes ☐ No ☐

If yes, explain : ______________________________

____

____

FINANCIAL STATUS

How will treatment be financed ______________________________

If your client is on Ministry of Employment and Income Assistance, Please Complete the following:

Office ______________________________ Phone ______________________________

Case Worker ______________________________ Phone ______________________________

Self paying clients must pay first month upon admission. ADS funded confirmation is required prior to admission.

SUBSTANCE ABUSE HISTORY

	SUBSTANCE	DURATION (YRS/MTHS)	LAST USE
1.)			
2.)			
3.)			
4.)			
5.)			
6.)			

Other addictions of concern: (ie: gambling, shopping)

____

____

PSYCHIATRIC HISTORY

Is the client currently mentally stable? (ie: recent hospitalizations) if not please explain.

Does the client have a history of treatment for mental health issues? (ie: therapist, counsellors, psychiatrist, psychologist)? If yes, please explain.

Is the client taking any medications related to psychiatric/mental health issues? If yes, please explain.

MEDICAL STATUS

Current Health: GOOD ☐ FAIR ☐ POOR ☐

Does the client present any special health care needs? If yes, explain.

LEGAL STATUS

Is the client on probation or parole? If yes, please explain.

Does the client have any pending charges/court appearances? If yes please explain.

SOCIAL HISTORY

Please write a brief history of the client's involvement with family, friends and significant others.

CASE MANAGER ASSESSMENT OF CLIENT

Please provide a brief statement about the client's strengths, goals, and perceived positional. What makes you think this client is suitable for a residential program rather that day treatment or outpatient counselling?

Not done yet, see next page for HoNOS survey.

Health of the Nation Outcome Scales (HoNOS) - Adult

- **Rate** each scale in order from 1 to 12
- **Do not** include information rated in an earlier item except for item 10 which is an overall rating
- **Rate** the MOST SEVERE problem that occurred during the period rated
- **All scales** follow the format:

0 = no problem
1 = minor problem requiring no action
2 = mild problem but definitely present
3 = moderately severe problem
4 = severe to very severe problem

Rate 9 if unknown

Item	Scale	
1. Overactive, aggressive, disruptive or agitated behaviour	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 associated with hallucinations and delusions	0 1 2 3 4	
7. Problems with depressed mood	0 1 2 3 4	
8. Other mental and behavioural 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	

RELEASE OF INFORMATION

When signing this form please inform your client they are consenting to the release of information to you, the Referral agent, and the funding agent (where necessary), regarding their relationship with Westminster House and their process of admission.

Your attention to this referral form is greatly appreciated and we thank you in advance for your co-operation in taking the time to fill it out. It will assist our team in addressing the particular needs of each of our clients. If you Have any questions; please contact our staff at 604-524-5633 or 866-524-5633 Fax: 604-524-4634.

Referral Agent Signature: ______________________________

Client Signature: ______________________________

Note: Funding agency must be filled by completed (only) when funded by public funding sources such as MHSD.

Clint Name ______________________________

Client S.I.N ______________________________

Funding Agency: ______________________________

WESTMINSTER HOUSE
RECOVERY CENTRE FOR WOMEN

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