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Substance Use Bed Based Treatment

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: If response is yes, mothers and young children can access specific services.

D: Please answer if the person is attending withdrawal management and if not, what is the reason. If yes, indicate the planned 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) need to be 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. Details of tertiary sites to include: Forensic Hospital, Burnaby Centre for Mental Health and Addictions or Heartwood Women's Treatment Centre

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 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.
- Detail all medications with dose, frequency and prescribing doctor

Legal & Financial Information:

- Please include any upcoming court dates for consideration of admission date, as well as copies of orders
- Financial Information:
  - source of payment must be confirmed
  - persons with Aboriginal status or veterans may be eligible for federal funding
  - if the person is eligible for income assistance, then suggest that they apply at www.myselfserve.gov.bc.ca.
  - if the person is not eligible for income assistance but still requires supplemental income, complete an Accommodation Fee Subsidy form and send it to afs@fraserhealth.ca in tandem with the referral

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 indicates they agree to the referral, the cost and for the release of information for the purpose of the referral.

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

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Note: Referrals must be typed and complete to be screened

Required: ☐ Early Exit Plan Attached

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

☐ Medical report on physical condition ☐ Recent psychiatric assessment (within 3 months)
☐ Multidisciplinary reports/assessments (social work, nursing notes) ☐ Neuro/cognitive assessment
☐ Recent addiction physician assessment (within 3 months) ☐ Probation conditions and/or court orders

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)*: Details:

Primary Phone: Email:

Person's preferences regarding contact: ☐ days ☐ evenings

OK to leave message? ☐ Yes ☐ No

Alternative/Emergency contact Name:

Phone: Email:

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

Name: Agency:

Email #1: Email #2:

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/chronic ideation 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 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#:

Ph: Fax:

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:

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

If yes describe

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

If yes describe

Does the person have chronic pain? ☐ Yes ☐ No

If yes describe

Does this person have dietary needs **not related** to food allergies? ☐ Yes ☐ No

Details:

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

List:

Other health considerations:

Tuberculosis Test: last known date:

Physician's Name: Agency:

Phone: Fax: Email:

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 **and attach a copy of probation orders or court orders:**

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

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

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

Plan G coverage: ☐ Yes ☐ No

Third part Pharmacy coverage: ☐ Yes ☐ No Indicate:

How will the user fee be paid:

☐ Income assistance (has an application been made? ☐ Yes ☐ No)

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

☐ Aboriginal Services ☐ Veteran's Affairs ☐ First Nations Health Authority

Payer information:

Name of Person or Agency/Company (if other than I.A. or AFS):

Phone: Email:

Other Relevant Information

Other Agency involvement: ☐ Yes ☐ No

If yes, please provide details:

Safety considerations? ☐ Yes ☐ No If yes details (ex: fire risks):

Are there any spiritual or religious practices/ceremonies that will support the person's wellness while in a bed based facility:

Are there preferences in the types of programs offered at the bed based 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

Indicate if person has a preferred bed based program in mind?

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 Bed Based 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

My Early Exit Transition Plan

The following plan will be put in place if I leave early from _____.
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 emergency contact will be notified. My plan includes a safe place to go and how I will get there.

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

Community Contact for Early Exit Support:

Who I can contact: Telephone #_____ Email address: _____	Who staff can contact: Telephone # _____ Email address: _____
My medical reminders:	Special considerations:

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 for safe travel. I will have these funds available to me upon intake.

My Signature:	Date: