### Please PRINT this form and fax the completed copy to 604-524-4634 or email info@westminsterhousE.ca

# REFERRING AGENTS, PLEASE NOTE:

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

A referral received without the client on the waitlist will only be held for 48 hours. Clients applying for a funded bed must complete the release of information included in this document.

## INTAKE OFFICE:

Toll-Free: 1-866-524-5633

Office: 604-524-5633

Fax: 604-524-4634

Email: info@westminsterhouse.ca

Address: 228 Seventh Street, New Westminster, BC V3M 3K3

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

* Call every day to check in with any Westminster House Staff. All check-ins are documented. Clients who do not call in within two weeks will be taken off the waitlist.
* Funding confirmation in place
* Confirmation of T.B. 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 the bed, dress. |
| 7:00 AM | - | Breakfast |
| 7:40 AM | - | Leave for 12 step meeting. |
| 10:00 AM | - | Group |
| 12:15 PM | - | Lunch |
| Afternoon | - | Planned Activities |
| 5:15 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 determine the client's suitability for the program. To ensure this client gets the best outcome from treatment, please complete the form as thoroughly as possible.

|  |
| --- |
| REFERRING AGENCY INFORMATION |
|  |  |  |  |
| Date | Click or tap here to enter text.  |  |  |
|  |  |  |  |
| Referring Agent |  Click or tap here to enter text. |
| Agency Address | Click or tap here to enter text. |
| City | Click or tap here to enter text. | Postal Code |  Click or tap here to enter text. |
| Phone |  Click or tap here to enter text. | Fax |   |
| Email | Click or tap here to enter text.  |  |  |
| Do you want to contact this client while in treatment at WHS?  | Yes [ ] No [ ]  |
| If yes, how often do you wish to contact this client? |  |
| CLIENT INFORMATION |
|  |  |  |  |
| Is the client aware that this is a non-smoking program? | Yes [ ]  No [ ]  |  |
|  |  |  |  |
| Name |  Click or tap here to enter text. |
| Address |  Click or tap here to enter text. |
| City |  Click or tap here to enter text. | Postal Code |  Click or tap here to enter text. |
| Phone |  Click or tap here to enter text. | Other |  Click or tap here to enter text. |
| Email |  Click or tap here to enter text. | DOB | Click or tap here to enter text. |
| SIN |  Click or tap here to enter text. | Medical # |  Click or tap here to enter text. |
| Marital Status |  Click or tap here to enter text. | Employment  |  Click or tap here to enter text. |
| Physician | Click or tap here to enter text.  | Phone |  Click or tap here to enter text. |
| Next of Kin |  Click or tap here to enter text. | Phone |   |

Are your immunizations up to date? Yes [ ]  No [ ]

Are you vaccinated against COVID 19 Yes [ ]  No [ ]

Do you have a record of your immunizations? Yes [ ]  No [ ]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MedicalDoes the client have any special health care needs? Yes [ ]  No [ ]

|  |  |
| --- | --- |
| If yes, explain: |  |
| Click or tap here to enter text. |  |

Is the client on any prescribed medications? Yes [ ]  No [ ]  |  |
| Current Medications (attach M.A.R. sheet where applicable): |   |  |
| Click or tap here to enter text. |  |  |
| Has the client been diagnosed with an eating disorder? Yes [ ]  No [ ]  |  |
| If yes, explain: |  |
| Click or tap here to enter text. |  |

 Does the client have any allergies? Yes [ ]  No [ ]

|  |  |
| --- | --- |
| If yes, explain: |  |
| Click or tap here to enter text. |  |

 Does the client have any Physical Limitations? Yes [ ]  No [ ]

|  |  |
| --- | --- |
| If yes, explain: |  |
| Click or tap here to enter text. |  |

|  |
| --- |
| FINANCIAL STATUS |
| How will treatment be financed? | Click or tap here to enter text.   |
| Name |   Click or tap here to enter text. | Phone |  Click or tap here to enter text. |
| Name | Click or tap here to enter text.  | Phone | Click or tap here to enter text.  |
|  |
| SUBSTANCE ABUSE HISTORY |
|  |
|

|  |  |  |
| --- | --- | --- |
| Substance | Age of first use | Last day/date used (approx.) |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

 |
| Other addictions of concern: (i.e., gambling, shopping) |  |  |
| Click or tap here to enter text.  |
|  |
| PSYCHIATRIC HISTORY |
| Is the client currently mentally stable? (i.e., recent hospitalizations). |
| If NOT, explain:  |
| Click or tap here to enter text. |
| Does the client have a history of treatment for mental health issues? (i.e., therapist, counsellors, psychiatrist,Psychologist)? Yes [ ]  No [ ]  |
| If yes, explain: |
| Click or tap here to enter text. |
| Is the client taking any medications related to psychiatric/mental health issues? (attach M.A.R. sheet where necessary) Yes [ ]  No [ ]  |
| If yes, explain:  |
| Click or tap here to enter text.  |
| LEGAL STATUS |
| Is the client on probation or parole? Yes [ ]  No [ ]  |
| If yes, explain: |
| Click or tap here to enter text. |
| Does the client have any pending charges/court appearances? Yes [ ]  No [ ]  |
| If yes, explain:  |
|  Click or tap here to enter text. |
| SOCIAL HISTORYPlease briefly describe the client's involvement with family, friends, and significant others. |
|  Click or tap here to enter text. |
| REFERRING AGENT ASSESSMENT OF THE CLIENT |
| Please briefly describe the client's strengths, goals, and perceived situation. What makes you think this client is suitable for a residential program? |
| Click or tap here to enter text. |

# EARLY EXIT TRANSITION PLAN

The following will be put into place if the client is discharged on short notice, either A.C.A. (against clinical advice) or for non-compliance:

|  |
| --- |
| Community/Health Authority: Click or tap here to enter text. |
| Name of destination upon early exit:  Click or tap here to enter text. |
| Address of destination upon early exit: Click or tap here to enter text. |
| Community Contact for early exit support: Click or tap here to enter text. Phone: Click or tap here to enter text. |
| Shelter: Yes [ ]  No [ ]  Residence: Yes [ ]  No [ ]  |
| Comments: Click or tap here to enter text. |
| Other Supportive Housing: Click or tap here to enter text. |
| Emergency Contact (this person will be contacted upon unsupported discharge) Phone: Click or tap here to enter text. |

Not done yet; see the next page for the 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 present

3 = moderately severe problem

4 = severe to very severe problem

|  |  |
| --- | --- |
|  | Rate 9 if unknown |
| 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 consent to release information to you, the Referral agent, and the funding agent (where necessary) regarding their relationship with Westminster House and their admission process.Your attention to this referral form is greatly appreciated, and we thank you in advance for your cooperation in filling it out. It will assist our team in addressing the particular needs of each of our clients. If you have any questions, please get in touch with our staff at 604-524-5633 or 866-524-5633. Fax: 604-524-4634. |
|  |
| Referral Agent Name: | Click or tap here to enter text.  Phone: Click or tap here to enter text. |
| Referring Agent Signature: |   |
| Client Name: | Click or tap here to enter text. |
| Client Signature:  |  |
| Note: Funding agency must be filled by completed (only) when funded by public funding sources such as MHSD. |
| Clint Name | Click or tap here to enter text. |
| Client Health Care # | Click or tap here to enter text. |
| Funding Agency: | Click or tap here to enter text. |

# M.S.P. – PREMIUM ASSISTANCE APPLICATION

All Westminster House clients must complete the application from premium assistance, or the consequence will be that the client will not be eligible for extra coverage for healthcare.

<http://www2.gov.bc.ca/assets/gov/health/forms/119fil.pdf>



228 Seventh Street

New Westminster, BC V3M 3K3 - Tel: 604-524-5633 - Fax: 604-524-4634

Email: info@westminsterhouse.ca