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.	5:15 PM	-	Dinner
7:00 AM	-	Breakfast	Evening	-	12 Step Meeting
7:40 AM	-	Leave for 12 step meeting.	10:00 PM	-	Curfew
10:00 AM	-	Group	10:30 PM	-	Bed Time
12:15 PM	-	Lunch	11:00 PM	-	Lights Out
Afternoon	-	Planned Activities			

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 ______________________________

Referring Agent ______________________________

Agency Address ______________________________

City ______________________________ Postal Code ____________________

Phone ______________________________ Fax ____________________

Email ______________________________

Do you want to contact this client while in treatment at W'House? 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 ______________________________

Address ______________________________

City ______________________________ Postal Code ____________________

Phone ______________________________ Other ____________________

Email ______________________________ DOB ____________________

SIN ______________________________ Medical # ____________________

Marital Status ______________________________ Employment ____________________

Physician ______________________________ Phone ____________________

Next of Kin ______________________________ Phone ____________________

Are your immunizations up to date? Yes ☐ No ☐

Do you have a record of your immunizations? Yes ☐ No ☐

MEDICAL

Does the client have any special health care needs? Yes ☐ No ☐

If yes, explain : ______________________________

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

Current Medications (attach M.A.R. sheet where applicable): ______________________________

Has the client been diagnosed with an eating disorder? Yes ☐ No ☐

If yes, explain : ______________________________

Does the client have any allergies? Yes ☐ No ☐

If yes, explain : ______________________________

Does the client have any Physical Limitations? Yes ☐ No ☐

If yes, explain : ______________________________

FINANCIAL STATUS

How will treatment be financed? ______________________________

Name ______________________________ Phone ______________________________

Name ______________________________ Phone ______________________________

SUBSTANCE ABUSE HISTORY

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

Other addictions of concern: (i.e., gambling, shopping)

____

____

PSYCHIATRIC HISTORY

Is the client currently mentally stable? (i.e., recent hospitalizations).

If NOT, explain: ______________________________

____

____

Does the client have a history of treatment for mental health issues? (i.e., therapist, counsellors, psychiatrist, Psychologist)?

If yes, explain:

Is the client taking any medications related to psychiatric/mental health issues? (attach M.A.R. sheet where necessary)

If yes, explain:

LEGAL STATUS

Is the client on probation or parole?

If yes, explain:

Does the client have any pending charges/court appearances?

If yes, explain:

SOCIAL HISTORY

Please briefly describe the client's involvement with family, friends and significant others.

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?

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: ______

Name of destination upon early exit: ______

Address of destination upon early exit: ______

Community Contact for early exit support: ______ Phone: ______

Shelter: Yes ☐ No ☐ Residence: Yes ☐ No ☐

Comments: ______

Other Supportive Housing: ______

Emergency Contact (this person will be contacted upon unsupported discharge) Phone: ______

Not done yet; see the 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 present

    3 = moderately severe problem

    4 = severe to very severe problem

Item	Scale	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 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 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: ______________________ Phone: ______________

Referring Agent Signature: ______________________

Client Name: ______________________

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: ______________________

M.S.P. – PREMIUM ASSISTANCE APPLICATION

All Westminster House clients must complete the application from premium assistance.

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

228 Seventh Street

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