Referral Form

Referral Source (Name & Agency): _____

Address: _____

Telephone#: _____ Fax#: _____

Name of Client: _____ Date of birth (m/d/y): _____

S.I.N.: _____ P.H.N: _____

Telephone#: _____ Fax#: _____

Past Treatment Centers (M/Y): _____

Date Last Used: _____ Methadone Maintenance Program: Yes ☐ ☐

Drugs of Choice: _____ Detoxed: Yes ☐ No ☐

Current Legal Issues (Outstanding warrant, charges, probation, parole, active court cases?):

_____

Past convictions & incarcerations: _____

_____

Physical health conditions: _____

Mental health conditions: _____

Medications: _____

Funding source: ☐ MHSD ☐ PWD ☐ Self ☐ EI ☐ Other: _____

Anticipated entry date (M/D/Y): _____

Emergency contact Name: _____ Telephone#: _____

All applicants having any outstanding legal, family or employment obligations must disclose this prior to admission. Clients must have abstained from drugs and/or alcohol for a minimum of 5 days (if coming from Detox) and 14 days if coming from elsewhere prior to admission.

Release of Information between Referral Agency and New Life Community Kamloops (NLC) Men's Recovery

I, _____ , have read and understand the above conditions for admission into at the NLC Men's Recovery. I authorize NLC to obtain any pertinent information from the referring agency.

_____ _____

Client Signature Date:

SUBSTANCE MISUSE PROFILE							
Principle Route ((#) options				**Level of Use (#) options**			
1.Mouth	2. Nose	3. Smoke	4. Inject	1.Does Not Apply	2. Light	3. Moderate	4. Heavy

Stage of Change (#) option				
1. Pre-contemplative	2. Contemplative	3. Preparation	4. Preparation	5. Action
6. Relapse	6. Maintenance	7. Unknown		

SUBSTANCE MISUSE PROFILE								
	Clinical Perspective					Client Perspective		
Substance	**Used**	**Detoxed Y/N**	**#day /mo**	**Principle Route**	**Date of Last Use**	**Level of Use**	**Dependence**	**Stage of Change**
Alcohol	☐						☐	
Marijuana	☐						☐	
Cocaine	☐						☐	
Crack Cocaine	☐						☐	
Methamphetamine/ Crystal Meth	☐						☐	
Heroin	☐						☐	
Methadone	☐						☐	
Other Opiates (e.g. morphine, codeine etc)	☐						☐	
Inhalants	☐						☐	
Hallucinogens	☐						☐	
Tobacco	☐						☐	
Ecstacy	☐						☐	
Other (describe)	☐						☐	
	☐						☐	

PREVIOUS ADDICTIONS SUPPORT/TREATMENT PROGRAMS

AGENCY/SERVICE	DATES	OUTCOMES	COMMENTS

Client's goal for seeking service now:

_____

_____

_____

If client has participated in programs in the past, what is different this time?

_____

_____

_____

Client's strengths in addressing substance use:

_____

_____

_____

What does client feel is his or her biggest challenge to recovery?

_____

_____

_____

PHYSICAL HEALTH

ALLERGIES (drug, food, environmental)

_____

_____

_____

PLEASE CHECK CONCERNS & COMMENT:

SENSORY - NEURO		HEART / CIRCULATION		GASTROINTESTINAL		MUSCULOSKELETAL	
Hearing problems	□	Blood pressure prob	□	Cirrhosis	□	Arthritis req meds	□
Vision problems	□	Heart disease	□	Malnutrition	□	Fracture	□
CVA (stroke)	□		□	Eating problems	□	Dental problems	□
Chronic pain req tx	□	**RESPIRATORY**	□	Bowel problems	□		□
Head injury	□	Asthma	□		□		□
Intellectual disability	□	COPD/Emphysema	□		□	**OTHER**	□
FASD	□		□	**REPRODUCTIVE**	□	Impaired mobility	□
Seizures	□	**Immune / Infection**	□	STI	□	Urinary incontinence	□
	□	Tuberculosis	□	Pregnancy	□	Fecal Incontinence	□
ENDOCRINE	□	Hepatitis B	□	Urinary bladder	□	Skin conditions	□
Diabetes – insulin	□	Hepatitis C	□		□	Wound/injuries	□
Diabetes – other	□	HIV	□		□	Other	□

COMMENTS:

_____

_____

_____

MEDICAL DIAGNOSIS / MAJOR ILLNESSES

_____

_____

_____

_____

CURRENT MEDICATIONS (prescription, Over-the-counter, supplements)

NAME OF MEDICATION	PURPOSE OF MEDICATION	FREQUENCY OF USE

METHADONE

Maintenance Therapy □ Yes □ No **Dose** _____ **Carries Permitted** □ Yes □ No

Prescribing Physician:_____

Address:_____

MENTAL HEALTH

Psychiatric History (diagnoses, hospitalizations, other treatments) □ Yes □ No

_____

_____

_____

Self-Harming Behaviours (eating disorders, slashing, burning) □ Yes □ No

_____

_____

_____

Suicide Risk □ Current □ Ideation □ Previous attempts

Details:

_____

_____

_____

Current Mood /Presenting Symptoms

Reported:

_____

_____

_____

_____

Observed:

_____

_____

_____

Special Needs:

□ Mobility □ Activities of daily living □ Literacy □ Cognitive function □ Brain Injury

LEVEL OF FUNCTIONING	HIGH	MEDIUM	LOW
Societal/Role Functioning			
Interpersonal Functioning			
Daily Living/Personal Care			

Comments:

HOUSING		RECOVERY NEEDS	
□	Will have safe, stable housing after residential program.	□	Has Identified Recovery Goals
□	Does not have safe stable housing.	□	Has a post recovery exit plan
□	Homeless	□	Has Family Support

Comments:

Carefully read each statement and decide if your answer is "Yes" or "No". Then circle the appropriate response beside the question.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

1. Are you always able to stop using drugs when you want to?	Yes No
2. Have you ever had "blackouts" or "flashbacks" as a result of your drug use?	Yes No
3. Do you ever feel bad or guilty about your drug use?	Yes No
4. Does your spouse (or parents) ever complain about your drug use?	Yes No
5. Has your drug abuse created problems between you and your partner or parents?	Yes No
6. Have you lost friends because of you use of drugs?	Yes No
7. Have you neglected your family because of your drug use?	Yes No
8. Have you ever been in trouble at work because of you drug abuse?	Yes No
9. Have you lost a job because of drug abuse?	Yes No
10. Have you gotten into fights when under the influence of drugs?	Yes No
11. Have you engaged in illegal activities in order to obtain drugs?	Yes No
12. Have you been arrested for possession of illegal drugs?	Yes No
13. Have you ever experienced withdrawal symptoms (felt sick) when you stopped	Yes No
14. Have you had medical problems as a result of your drug use?	Yes No
15. Have you gone to anyone for help for a drug problem?	Yes No
16. Have you been involved in a treatment program specifically related to drug use?	Yes No

The following questions are about your intake of alcohol during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No".

<u>These questions refer to the last 12 months</u>	**Circle your response**
1. Do you feel you are a normal drinker?	Yes No
2. Do your friends and relatives think you are a normal drinker?	Yes No
3. Have you ever attended a meeting of Alcoholic Anonymous (AA)?	Yes No
4. Have you lost friends, girlfriends/boyfriends because of your drinking?	Yes No
5. Have you gotten into trouble at work because of your drinking?	Yes No
6. Have you neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes No
7. Have you had delirium tremens (DT's), severe shaking, heard Voices or seen things that were not there after heavy drinking?	Yes No
8. Have you ever gone to anyone for help about your drinking?	Yes No
9. Have you been in hospital because of your drinking?	Yes No
10. Have you ever received a 24 hr roadside suspension or Have you been charged for impaired driving?	Yes No
Total = /20	

Consent for Release of Information

Name: _____ D.O.B. _____

I hereby consent to the release of medical, psychiatric, psychological, educational, financial, employment or family information from your records to the NLC Men's Recovery Manager. I understand it may be helpful or necessary for my counselor to speak to other professionals who may be involved in aspects of my physical and emotional health. Wherever possible, this will be done with my understanding the intent of such contact. I have the right to know what transpired in any conversation between my counselor and other professionals. I understand that this information may be used in my psychosocial rehabilitation process and may be taken into account in decisions made at New Life Community Kamloops.

Support Network	Name:	Phone Number	Initials
Probation/Parole Officer			
Alcohol & Drug Counselor			
Mental Health Worker			
Forensic Services			
Psychiatrist/Psychologist			
Doctor/ Medical Physician			
Family Members			
Social/Case Worker			
Other (Specify)			

_____ _____

Client Signature **Date Signed**

ADMISSION AGREEMENT

I,_____, do not have any outstanding legal, medical, family or employment obligation that I am not willing to set aside for the duration of my time in a residential recovery program so that I can focus on my addictions recovery and benefit from the program. I agree to have a medical exam prior to, or on admittance to the program. I have abstained from alcohol and other drugs for a minimum of 14 days prior to admission or as directed. *I agree to remain abstinent from alcohol and other drugs for duration of the program.* **I understand that if I do not comply with house rules that I will be asked to leave the program.** I have read and understood the above conditions for services. I authorize the residential agency to obtain any pertinent information from the referring agency. I agree to participate in the program offered, and agree to do my part to keep the residential service a safe place for recovery.

Client Signature: _____ Date:_____