

**CLIENT REFERRAL AND INTAKE PACKAGE**

**CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Part 1: Client Personal Information** |
| Last Name: |  |  |  | First Name: |  |  |  |
| MSP PHN: |  |  |  | SIN: |  |  |  |
| Date of Birth: |  |  |  | Age: |  |  |  |  |
|  | dd | mm | yyyy |  |  |  |  |  |
| Marital Status: |  Single Common-Law/ Married Divorced/Separated Widowed  |
| Number of Children |  | With whom do they live with? |  |
| Are your children in MCFD or Aboriginal CFS care? |  Yes No |
| Income Source: |  IA EI STD/ WCB CPP Employment None*If client has no source of income initiate income assistance application* |

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| **Part 2: Indigenous**  |
| *Does client self identify as indigenous? \_\_\_\_ Yes \_\_\_\_ No Status #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes complete this section, if no skip to Part 3.* |
| Legal Status: Status Indian Metis Inuit Non-Status Aboriginal |
| First Nation | Indigenous Nation: |
| Indigenous Language Spoken?  |  |
|  Residential School History: Self In family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Check all that apply:*Childhood? With parents With Extended Family In Foster Care Adopted *If client indicated a childhood experience with foster care and/or adoption initiate referral for trauma based counselling*. |
| Do you practice traditional indigenous spirituality? Yes No  |
| If so, which ceremonies do you participate in? |
| Are there any specific cultural goals we could assist with? |
| Notes: |

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| **Part 3: Social Assessment** |
| What circumstances led you to seek support services at 333 Trinity Men’s Recovery House?:*Note: Ensure client provides a thorough summary of their presenting circumstances* |
| Are you employed? Yes No If yes, employer name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What is your usual occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Highest Education Completed Less than Grade XII Grade completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High School Diploma College/ University Program Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Note: If client desires educational upgrading, inform them that this can be a part of after-care plan.* |
| Where have you been living in the past 90 days? (Check all that apply) In own home With family members Homeless Hospital Jail OtherIf client has been homeless, where were they staying?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does client have a housing worker? Yes No Worker Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Inform client of second stage housing program that is available post treatment.* |
| Notes: |

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| **Part 4: Legal Assessment** |
| *Is client currently or have previously been involved in the legal system? \_\_\_\_ Yes \_\_\_ No**If yes, complete this section. If no, skip to Part 5* |
| Is client on bail? \_\_\_\_ Yes \_\_\_\_ No *If yes, verify if bail order is included in client file.* |
| Is client on probation or a CSO? \_\_\_ Yes \_\_\_\_ NoProbation Officer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*If yes, verify if probation order is included in client file.* |
| What are your current charges?  |
| Do you have previous charges that have not yet been granted a record suspension? \_\_\_\_ Yes \_\_\_\_ NoIf yes, please describe:*If client indicates a current or past history of sexual related offences, inform Program Director* |

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| **Part 5: Drivers Licence** |
| Does client have a valid N or Full Drivers Licence: \_\_\_\_ Yes \_\_\_\_ No*If yes, ask if client would like to become a volunteer driver and obtain ICBC abstract.**If no, inform client that a possible after care goal may be to obtain or re-acquire driver’s licence.* |

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| **Part 6: Medical Assessment** |
| Medical conditions/ major illnesses: (i.e. diabetes, cancer, emphysema) |
| Other diagnosis or chronic conditions: |
| Do you have the following conditions? TB HIV/ AIDS Hep A/B/C Have you been tested? \_\_\_ Yes \_\_\_ No Date of last test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Family Doctor Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*List any specialists on the client release form and if client requires medical care inform of our medical clinic partners.* |
| Have you seen a dentist in the past 12 months? \_\_\_ Yes \_\_\_ No*If client has not seen dentist, offer a referral to our dental partner.* |
| Current Medications: |
| Name and dosage | Condition treated? | How long? |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| *Ensure that client prescriptions have been transferred to our pharmacy partner* |
| *Please confirm if allergy, special diet and special needs have been completed and included in client file If this information has not been entered, please obtain from client.*Notes: |
| Previous Hospitalizations: |
| Hospital Name | Reason and treatment provided |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |
| Notes: |

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| **Part 7: Mental Health Assessment** |
| *Does client have a current or past history of mental illness? \_\_\_\_ Yes \_\_\_\_No**If yes, complete this section. If no skip to Section 8.* |
| Mental Health Diagnosis |
| Diagnosis | When Diagnosis Given | Symptoms |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| Do you have a current or a past history of self harming behaviour or suicide attempts?\_\_\_\_\_\_ Yes \_\_\_\_\_\_ No. If yes, please describe:*Note: If client has been in hospital within the past 90 days for self harming behaviour or a suicide attempt, obtain a copy of client safety plan completed at discharge and review this with client.* |
| Do you now or have you recently had suicidal thoughts? \_\_\_\_ Yes \_\_\_\_ No*If client answers yes, ask probing questions about the client’s resources and also whether they are connected with mental health services. If they are not connected, initiate referral to mental health services. Inform them they may approach staff at any time for help.* |
| Do you hear voices or hallucinate (except for when in withdrawal?) \_\_\_\_ Yes \_\_\_\_ NoHave you ever been in psychosis? \_\_\_\_\_ Yes \_\_\_\_ NoDo you experience panic attacks? \_\_\_\_\_ Yes \_\_\_\_ No*If client answers yes, ask probing questions about the medications/ therapeutic interventions that are in place. If they have none, initiate referral to mental health services.* |
| Psychiatrist Name: Phone Number: |
| Mental Health Team: Phone Number |
| Notes: *(Observation of client mood)* |

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| **Part 8: Opioid Agonist Therapy** |
| *Is client on opioid agonist therapy? \_\_\_\_ Yes \_\_\_\_ No**If yes, complete, if no skip to Part 9* |
| Medication prescribed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maintenance \_\_\_\_\_\_ Taper |
| Prescribing Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Refer client to OAT clinic if possible and transfer prescription to pharmacy partner. Advise client that we require a daily dispense during primary treatment.* |

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| **Part 9: Substance Abuse Assessment** |
| **Substance Use History.***Fill in for each substance used, cross line if not applicable* | **Method**1 – Oral2 -Snort/Sniff3 -Smoke/ Chase4- Intravenous5- Intramuscular | **Amount** | **Frequency** | **Years of Use** | **Date last used** |
| Alcohol |  |  |  |  |  |
| Barbiturates |  |  |  |  |  |
| Benzodiazepines |  |  |  |  |  |
| Cannabis |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Crack |  |  |  |  |  |
| Crystal Meth |  |  |  |  |  |
| Ecstasy |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |
| Heroin |  |  |  |  |  |
| Illicit Methadone |  |  |  |  |  |
| Inhalants |  |  |  |  |  |
| Nicotine |  |  |  |  |  |
| Opiates (other than heroin/methadone) |  |  |  |  |  |
| Misuse of Prescription Drugs |  |  |  |  |  |
| Speedball |  |  |  |  |  |
| Club Drugs |  |  |  |  |  |
| Designer Drugs |  |  |  |  |  |
| Other |  |  |  |  |  |
| Previous Treatment History: |
| Treatment Centre Name | Dates Attended | Outcome/Comments |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| Notes: |

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| **Part 10: Life Areas** |
| *Read the following list to the client and ask them to rank where they are in the following life areas. Do not hesitate to ask probing questions on each of the topics to gain a better understanding.* |
|  | Poor (1) | Fair (2) | Good(3) | Excellent (4) |
| Ability to deal with drugs and alcohol today? |  |  |  |  |
| Physical Health |  |  |  |  |
| Mental/ Emotional Health |  |  |  |  |
| Family Relationships (i.e. with parents, children etc.) |  |  |  |  |
| Relationships with Friends |  |  |  |  |
| Employment/ Education |  |  |  |  |
| Criminal Justice Involvement |  |  |  |  |
| Housing Conditions |  |  |  |  |
| Finances |  |  |  |  |
| Social Activities |  |  |  |  |
| Relations with Significant Other (if applicable) |  |  |  |  |
| Spirituality |  |  |  |  |
| Ability to deal with anger |  |  |  |  |
| Ability to deal with stress |  |  |  |  |
| Communication skills |  |  |  |  |
| Assertiveness |  |  |  |  |
| Ability to express feelings |  |  |  |  |
| Ability to relax |  |  |  |  |
| Self-confidence and self- esteem |  |  |  |  |
| Self-Awareness |  |  |  |  |
| Please create THREE treatment goals in addition to the example |
| *I want to learn the skills to stay clean and sober from drugs and alcohol.* |
| 1. |
| 2. |
| 3. |
| Notes: |

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| **Part 11: Personal Service Plan** |
| 333 Trinity Men’s Recovery House is entering into a residency agreement with you and will be providing support services as prescribed by the *Community Care and Assisted Living Act*. We provide supportive programming, hospitality services and medication management according to the CCALA. Each client will follow an individual support plan with the support of 333 Trinity Men’s Recovery House staff. We are committed to supporting you in your recovery journey; in return we ask that you commit to a willingness to change and to confront the factors leading to your addiction. You are asked to become familiar with the *Program Guide* and if you have any questions about your personal service plan, feel free to approach staff.General Service Plan:Client will reside at 333 Trinity Men’s Recovery House for at least 60 days.Three meals and a snack are provided each day taking into consideration any dietary restrictions. Client will inform staff of any food allergies and/or food intolerances.Client agrees that medications will be stored, and staff will dispense them as needed. Client will self-administer any medications.Client commits to attending daily addiction group sessions.Client will complete homework assignments.Client will attend in house meetings and community 12 step meetings.Client will maintain a journal.Client will pursue employment, education, or volunteer opportunities in after care phase.Individual Service PlanClient will be in \_\_\_Pre Treatment Stabilization Program \_\_\_Recovery Based Programming  \_\_\_After care supportMenu Plan: \_\_\_Standard Menu  \_\_\_Dietary Modification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If client is to be referred to residential treatment, which treatment centre is the client planning to attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Has application be made? \_\_\_\_Yes \_\_\_\_No Will application assistance be needed? \_\_\_\_Yes \_\_\_NoReferrals will be made to the following partner organizations: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Notes: |

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| **Part 12: Consent to Release Information** |
| I **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** a client of the 333 Trinity Men’s Recovery House program understand that the information provided in this assessment will be shared among 333 Trinity Men’s Recovery House staff involved in my care. I give permission to 333 Trinity Men’s Recovery House to release information to the following persons/ organizations. I also agree that 333 Trinity Men’s Recovery House may receive information from the following persons/ organizations: |
|  | **Name** | **Organization** | **Telephone** | **Initial if permission to contact is granted** |
| Physician |  |  |  |  |
| Addictions physician |  |  |  |  |
| Psychiatrist |  |  |  |  |
| Mental Health Team |  |  |  |  |
| A &D Counselling |  |  |  |  |
| Health Centre |  |  |  |  |
| Dual Diagnosis |  |  |  |  |
| Income Assistance |  |  |  |  |
| MCFD Social Worker |  |  |  |  |
| Lawyer |  |  |  |  |
| Parole/ Probation |  |  |  |  |
| Employer |  |  |  |  |
| Family/Friend |  |  |  |  |
| Other |  |  |  |  |
| Client signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed name of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Part 13: Confidentiality Statement** |
| Information received through the counselling relationship is confidential. The confidentiality agreement is shared among 333 Trinity Men’s Recovery House staff involved with your care. Client information is considered confidential by 333 Trinity Men’s Recovery House staff and will not be voluntarily divulged to a third party without the client's consent.There are statutory exceptions to confidentiality:1. ***Potential Harm to Self-*** If the behaviour or words of the client threatens potential harm to themselves, 333 Trinity Men’s Recovery House staff must by law inform the proper authorities.
2. ***Potential Harm to Others***- If the behaviour or words of the client threatens potential harm to another individual/ group of people or property, 333 Trinity Men’s Recovery House staff has a lawful duty to warn and to take appropriate action to protect other individuals, groups, or property by informing the proper authorities.
3. ***Protection of Vulnerable Persons***- If 333 Trinity Men’s Recovery House staff has reason to believe that a child, elderly or another vulnerable person is or might be in need of protection, the staff member has a legal obligation to forthwith inform the proper authorities.
4. ***Legal Requirements***- 333 Trinity Men’s Recovery House staff may be required to provide records or disclose personal and confidential information by lawful order of a court in British Columbia.
5. ***Consent to Release Information-*** 333 Trinity Men’s Recovery House staff may release information to the individuals/ organizations that the client has completed on the Release of Information form.

I have had the Confidentiality Statement read to me and I understand the guidelines that limit my rights to confidentiality.Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| I name the below listed person as an emergency contact and authorize 333 Trinity Men’s Recovery House to contact them if required.Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Part 14: Early Exit Transition Plan** |
| If I leave 333 Trinity Men’s Recovery House prior to program completion, I agree to use the support of staff for resource information and safe transition planning. I will either:\_\_\_ Return to my home or the home of the individual(s) named below for immediate housing and transition support.And/or\_\_\_\_Contact the agency/ worker named below for immediate shelter and transition support.Early Exit Support Persons**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Worker Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Additional Information: |
| **Part 15: Client Agreement** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(full name) am voluntarily applying for services at 333 Trinity Men’s Recovery House. I understand that I am free to terminate my residency at any time and that 333 Trinity Men’s Recovery House may terminate my residency if I fail to abide by program rules as listed in the *Program Guide*.I agree that while I am at 333 Trinity Men’s Recovery House I will:\_\_\_ Follow all program guidelines as listed in the *Program Guide*.\_\_\_Honour and respect other clients and staff including maintaining confidentiality.\_\_\_Agree to cooperate with my Personal Service Plan to the best of my ability. I understand this plan may be varied during my stay and will be reviewed monthly.\_\_\_Agree to submit to random urinalysis and/or breathalyzer samples and understand that refusal to submit to testing will result in discharge.Client signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed name of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |