



PARTICIPANT REFERRAL AND INTAKE PACKAGE

PARTICIPANT'S NAME: _____

Part 1: Client Personal Information						
Last Name:				First Name:		
MSP PHN:				SIN:		
Date of Birth:				Age:		
dd mm yyyy						
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Common-Law/ Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed					
Number of Children			With whom do they live with?			
Are your children in MCFD or Aboriginal CFS care?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Income Source:	<input type="checkbox"/> IA <input type="checkbox"/> EI <input type="checkbox"/> STD/ WCB <input type="checkbox"/> CPP <input type="checkbox"/> Employment <input type="checkbox"/> None					

Part 2: Indigenous	
Do you self identify as indigenous? ___ Yes ___ No Status # _____	
<i>If yes complete this section, if no skip to Part 3.</i>	
Legal Status: <input type="checkbox"/> Status Indian <input type="checkbox"/> Metis <input type="checkbox"/> Inuit <input type="checkbox"/> Non-Status Aboriginal	
First Nation	Indigenous Nation:
Indigenous Language Spoken?	
Residential School History: <input type="checkbox"/> Self <input type="checkbox"/> In family: _____	
<i>Check all that apply:</i>	
Childhood? <input type="checkbox"/> With parents <input type="checkbox"/> With Extended Family <input type="checkbox"/> In Foster Care	
<input type="checkbox"/> Adopted	
Do you practice traditional indigenous spirituality? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, which ceremonies do you participate in?	
Are there any specific cultural goals we could assist with?	
Notes:	

Part 3: Social Assessment	
What circumstances led you to seek supportive services at 333 Trinity Men's Recovery House?:	
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, employer's name: _____ What is your usual occupation? _____	
Highest Education Completed <input type="checkbox"/> Less than Grade XII Grade completed: _____ <input type="checkbox"/> High School Diploma <input type="checkbox"/> College/ University Program Attended: _____.	
Where have you been living in the past 90 days? (Check all that apply) <input type="checkbox"/> In own home <input type="checkbox"/> with family members <input type="checkbox"/> Unhoused <input type="checkbox"/> Hospital <input type="checkbox"/> Jail <input type="checkbox"/> Other If client has been without housing, where were they staying? _____	
Does client have a housing worker? <input type="checkbox"/> Yes <input type="checkbox"/> No Worker Name: _____ Phone Number: _____	
Notes:	

Part 4: Legal Assessment	
Are you currently or previously involved in the legal system? ____ Yes ____ No <i>If yes, complete this section. If no, skip to Part 5</i>	
Are you on bail? ____ Yes ____ No <i>If yes, include a copy of the order.</i>	
Are you on probation or a CSO? ____ Yes ____ No Probation Officer Name: _____ Phone Number: _____ <i>If yes, include a copy of the order.</i>	
What are your current charges?	
Do you have previous charges that have not yet been granted a record suspension? ____ Yes ____ No If yes, please describe:	
<i>Any history of or current sexual related offences must be disclosed during the referral process. Not disclosing could result in an immediate discharge if uncovered after intake.</i>	

Part 5: Drivers Licence	
Does client have a valid N or Full Drivers Licence: ____ Yes ____ No Does client have a vehicle: ____ Yes ____ No	

Part 6: Medical Assessment		
Medical conditions/ major illnesses: (i.e. diabetes, cancer, emphysema)		
Other diagnosis or chronic conditions:		
Do you have the following conditions?		
<input type="checkbox"/> TB <input type="checkbox"/> HIV/ AIDS <input type="checkbox"/> Hep A/B/C Have you been tested? ___ Yes ___ No Date of last test: _____		
Family Doctor Name _____ Phone Number: _____		
Have you seen a dentist in the past 12 months? ___ Yes ___ No		
Current Medications:		
Name and dosage	Condition treated?	How long?
1.		
2.		
3.		
4.		
5.		
6.		
<i>Ensure that client has access to their medication and refills before their scheduled intake.</i>		
Notes:		
Previous Hospitalizations:		
Hospital Name	Reason and treatment provided	
1.		
2.		
3.		
4.		
5.		
6.		
Notes:		

Part 7: Mental Health Assessment		
Do you have a history of or currently have a mental illness? ___ Yes ___ No <i>If yes, complete this section. If no skip to Section 8.</i>		
Mental Health Diagnosis		
Diagnosis	When Diagnosis Given	Symptoms
1.		
2.		
3.		
4.		
5.		
Do you have a history of self harming behaviour or suicide attempts? _____ Yes _____ No. If yes, please describe: <i>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.</i>		
Do you now or have you recently had suicidal thoughts? ___ Yes ___ No <i>If client answers yes, initiate suicide risk assessment (if available) or make referral to mental health services for further assessment. If suicide risk is not imminent, continue referral.</i>		
Do you hear voices or hallucinate (except for when in withdrawal?) ___ Yes ___ No Have you ever been in psychosis? ___ Yes ___ No Do you experience panic attacks? ___ Yes ___ No <i>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.</i>		
Psychiatrist Name:		Phone Number:
Mental Health Team:		Phone Number
Notes: <i>(Observation of client mood)</i> 		

Part 8: Opioid Agonist Therapy	
Are you on opioid agonist therapy? ___ Yes ___ No <i>If yes, complete, if no skip to Part 9</i>	
Medication prescribed: _____	
Dose: _____	How long? _____
_____ Maintenance	_____ Taper
Prescribing Doctor: _____	Telephone: _____
<i>Advise client that we require a weekly dispense during primary treatment. Client must have access to their prescription set up before their scheduled intake.</i>	

Part 9: Substance Abuse Assessment					
Substance Use History. <i>Fill in for each substance used, cross line if not applicable</i>	Method 1 – Oral 2 -Snort/Sniff 3 -Smoke/ Chase 4- Intravenous 5- 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:					

Part 10: Life Areas				
<i>Read the following list and rank where you are in the following life areas.</i>				
	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>I want to learn the skills to stay clean and sober from drugs and alcohol.</i>				
1.				
2.				
3.				
Notes:				

Part 11: Personal Service Plan

333 Trinity Men's Recovery House is entering into a residency agreement with you and will be providing supportive recovery services as prescribed by the *Assisted Living Registry*. We provide supportive programming, hospitality services and medication management in accordance with the ALR. Each participant 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:

Participant will reside at 333 Trinity Men's Recovery House for at least 90 days.
 Three meals and a snack are provided each day taking into consideration any dietary restrictions. Participant will inform staff of any food allergies and/or food intolerances.
 Participant agrees that medications will be stored, and staff will dispense them as needed.
 Participant will self-administer any medications.
 Participant commits to attending daily addiction group sessions.
 Participant will complete assignments.
 Participant will attend in house meetings and community 12 step meetings.
 Participant will maintain a journal.

Menu Plan: ___ Standard Menu
 ___ Dietary Modification: _____

Are you planning to attend another program after completion? ___ Yes ___ No

Which program are you planning to attend? _____

Has the application been made? ___ Yes ___ No

Will application assistance be needed? ___ Yes ___ No

Notes:

Part 12: Consent to Release Information

I _____ a participant 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				

Participant Signature: _____ Date: _____

Printed name of participant: _____

Witness Signature: _____ Date: _____

Printed name of Witness: _____

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.

Participant signature: _____ Date: _____

Participant printed name: _____

Witness signature: _____ Date: _____

Witness 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: _____

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 _____
Cell Tel: _____

Name: _____
Relationship _____
Cell Tel: _____

Agency Name: _____
Worker Name: _____
Office Tel: _____
Cell Tel: _____

Additional Information:

Part 15: Participant 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*.

___ Participate in all programs and activities to the best of my ability.

___ Honor 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 weekly.

___ Agree to submit to random urinalysis and/or breathalyzer samples and understand that refusal to submit to testing will result in discharge.

Participant signature: _____ Date: _____

Printed name of participant: _____

Witness Signature: _____ Date: _____

Printed name of Witness: _____

Referral Worker Information

Name: _____

Organization: _____

Phone Number: _____

E-mail Address: _____