Provincial Youth and Young Adult Treatment Programs

Referral Package

Revised: June, 2024

Referral package completion checklist

Please note:

- This package is intended to be completed by a community support team member or a health care professional, in collaboration with the client
- It is preferred that the referral package is completed electronically with page 15 physically signed
- To check boxes electronically double click on the box and change the default value to 'Checked'

Before submitting to a local Health Authority for processing, please ensure the following tasks are complete: (To avoid excess printing, submit only pages 8 – 17)

- ☐ Complete the included referral form, fill in all applicable boxes
- ☐ Complete the program specific forms (client participation form) and attach to referral package
- ☐ Include the following collateral information if available and applicable:
  - **Current and recent** psychiatric and/or medical consults
  - Hospital admission/discharge notes
  - Relevant discharge summaries
  - Forensic assessments (if applicable)
  - Current MAR or list of medications
  - Probation/Bail/Parole orders (if applicable)
  - Current safety plan made in consultation with the client
- ☐ Complete series of Mental Health certificates (if applicable)
- ☐ In consultation with the client, complete the Early Exit Transition Plan section
- ☐ In consultation with the client, complete and attach the Participation Agreement. Please ensure it is signed.
- ☐ Review program specific client guide with the client (this can also be found on the program's web page)

The above components constitute a complete referral and will be reviewed by the program's Admission Committee once received from the Health Authority screening committee.

Provincial Substance Use Treatment Program – Youth and Young Adult **Inclusion Criteria**	**COAST Mental Health**	**Phoenix Society**
Program Mandate *The program mandate must match with the client's primary presenting concern(s). Other concerns can be addressed, as appropriate to each program, but should not be the primary concern.* *Please see Additional Considerations below.*	People who have a severe and/or high-risk substance use disorder. Clients may or may not have a stable co-occurring mild to moderate mental health disorder. Clients attend on a voluntary basis.	People who have a severe and/or high-risk substance use disorder. Clients may or may not have a stable co-occurring mild to moderate mental health disorder. Clients attend on a voluntary basis.
BC Resident	✓	✓
Age	17-24	17-24
Gender	Identifying Female and Non-Binary	Identifying Male and Non-Binary
Medically and Psychiatrically Stable (not requiring acute hospitalization)	✓	✓
Activities of Daily Living: Clients need to have the ability to be independent in their activities of daily living including eating, toileting, and mobilizing	✓	✓
Mental Health and Addiction Team or a Community Care Team Connection:	✓	✓
Offers involuntary treatment	**X**	**X**
	Considerations	
	Please contact the Access and Flow Coordinator or the Health Authority Liaison directly for questions about the below	
Severe violence including sexual violence	Applies	Applies
Sexual offences involving minors	Applies	Applies
Arson/Fire setting	Applies	Applies

Additional Considerations
The following will also be considered when assessing clients for appropriate treatment match and timing
To ensure safety for all, client milieu will be considered.
Capacity to benefit from group-based programming and ability to reside in communal living environment.
A recent history of physical violence.
Acute suicidality and ideation.

Program Transition/Discharge Criteria

Requests regarding early transitions/discharge from treatment program may include the following

- Physical, sexual or verbal threats/abuse/violence.
- Client's presentation or symptom severity requires care/treatment in acute care/other tertiary facility.
- Persistent pattern of alcohol or drug use and not engaging in safety or relapse prevention plans.
- Alcohol or drug use on premises or use during outings with staff.
- Attempted/recruitment of others into gangs or the sex trade.
- Recruiting co-clients into illegal or harmful activities.
- Drug dealing/sharing.

Referral process

Referrals can be completed by a referring agent in collaboration with the client. A referring agent can be one the following:

- Counsellor
- Social worker
- Physician
- Psychiatrist
- Community mental and addiction health team provider
- Psychologist
- Nurse practitioner
- Case manager

Referral process:

1. Referral agent forwards the completed referral package to their regional Health Authority Liaison.
2. Health Authority Liaison screens the referral for completeness and program suitability.
3. If approved by the Health Authority Liaison, the referral is sent to the Access and Flow Coordinator at the indicated BC Children's Hospital.
4. Once all required information is received by the Access and Flow Coordinator, the clinical team at the program reviews the referral within one to two weeks depending on program demand and volume of referrals.
5. If the referral is accepted, the Access and Flow Coordinator informs the Health Authority Liaison.
6. The Health Authority Liaison will place the client on their region's waitlist.
7. When a bed is available, the Health Authority Liaison is notified by the Access and Flow Coordinator.
8. The Health Authority Liaison prioritizes and identifies a client on the waitlist for the available bed.
9. The BC Children's Hospital Access and Flow Coordinator coordinates with the program/service provider to plan intake.

If a client is not a match for the requested BC Children's Hospital Substance Use Services program, a letter of alternate recommendations will be provided to the Health Authority Liaison. In the instance where another BC Children's Hospital program is a better match, the Health Authority Liaison will be advised and they have the option to forward the referral to the recommended program.

If there are any further questions please contact the Health Authority Liaison who will be able to assist in completing the referral packages and provide further information.

Please forward complete referrals to the specific Health Authority Liaison as detailed below:

Provincial Substance Use Treatment Program Health Authority Liaison Contacts

Health Authority	Liaison	Email	Phone	Fax
Fraser Health Authority	Shannon Smith	Shannon.smith@fraserhealth.ca	604-614-2383	604-519-8538
Interior Health Authority	Tasha McAdam	Tasha.Mcadam@interiorhealth.ca	250-469-7070 ext 12394	Please email
Island Health Authority	Douglas Hardie	douglas.hardie@islandhealth.ca	250-732-2368	**Please email**
Northern Health Authority	Youth: Brianne Boyd	brianne.boyd@northernhealth.ca	**Please email** 250 645-7415 (office)	**Please email** 250 645 8038
Vancouver Coastal Health Authority	Central Addiction Intake Team	CAIT.Youth@vch.ca	604-209-3705	604-255-1101
Provincial Access and Flow Coordinator	Rita Grewal	accessandflowyaya@cw.bc.ca	604-875-2155	N/A

Please note that each Health Authority will have their own criteria for processing referrals to Provincial Youth and Young Adult Substance Use Treatment program. Please check with your Health Authority Liaison for more information.

Client's referral information

Referral Date (**D/M/Y**):		Health Authority:		Is this a FNHA Referral?	☐ Yes	☐ No	
Client's Legal Name		Preferred Name		Program requested: (Coast/Phoenix)			
Referring agent's contact name:							
If referring agent is a hospital, name of hospital & unit:							
Referring Organization:							
Ph:		Fax:	kp;j	Email:			

Community care team information

Community Care Team:				
Community Case Manager Name:		Email		Ph:
Physician Name and Community Clinic Location		Ph:		Fax:
Psychiatrist Name:		Ph:		Fax:
Community Pharmacy:		Ph:		

Client information

Date of Birth (**D/M/Y**):		Age:		PHN:	CS/MRN Number:

Gender (tick all that apply): ☐ Female ☐ Male ☐ Transgender ☐ Non-Binary ☐ Two-Spirit ☐ Questioning ☐ My Gender is: ☐ Prefer not to answer

Pronoun: ☐ She ☐ He ☐ They ☐ My pronoun is :

Current Address:				City:	
Province:		Postal Code:		Ph:	Email:

Income & Medical/Pharmacy coverage

Income Source:

☐ MSDPR ☐ PWD ☐ Employment Insurance ☐ Long-term Disability ☐ CPP/CPPD

☐ Employed ☐ Other Income:

Type of medical/pharmacy coverage:		Third Party Insurer:	
Policy #:		ID#:	

Cultural information

Does the client identify as an Indigenous Person?	☐ Indigenous ☐ Non-Indigenous ☐ Client Declined, Ask again later ☐ Client Declined, Do not ask again ☐ Unknown
Indigenous Identity Group:	☐ First Nations ☐ First Nations & Inuit ☐ First Nations & Métis ☐ First Nations & Métis & Inuit ☐ Inuit ☐ Métis ☐ Métis & Inuit ☐ Unknown ☐ Outside of Canada ☐ No response
Predominantly lives:	☐ Both on & off reserve ☐ Off reserve ☐ On reserve ☐ No response
First Nations Status:	☐ Has Status ☐ Non Status ☐ Pending Status ☐ No response
Metis Citizenship:	☐ Has citizenship. Métis Citizenship #: ☐ Non citizenship ☐ Pending citizenship ☐ No response
Would you use Indigenous Patient Services?	☐ Yes ☐ No ☐ Maybe

Status card #:		Band:	

Ethnicity:		Primary Language:	Interpreter needed?	☐ Yes	☐ No

Provide details of language interpretation needs:

We invite the client to let us know if there are any spiritual, religious practices or ceremonies that will support their wellness while in treatment:

Emergency contact person (Family/Friend/Support person)

(Please note that the person below will be contacted should there be an emergent concern about safety, medical, etc.)

Name (first & last):		Relationship:	
Ph:		Email:	
Is there an identified Substitute Decision Maker (SDM)?	☐ Yes ☐ No	Name:	
Ph:		Email:	

Power of Attorney/Trustee

Is there a power of attorney in place?	☐ Yes	☐ No
If yes, provide a brief description: (e.g. finances, treatment decisions, etc.)		
Is there a trustee?	☐ Yes ☐ No	Name:
Ph:		Email:

Family involvement

Does the client have children?	☐ Yes ☐ No	# of children:	Age:
Are the children in foster care?	☐ Yes ☐ No	Is the client a custodial parent?	☐ Yes ☐ No
Name of custodial/foster parent(s):			
Custodial parent Ph:		Custodial parent email:	
If child(ren), what is current living situation?			
If applicable, what visits are available for the client with their child(ren)?			
Please provide details, including contact information and Ministry of Children and Family Development contact information (if appropriate):			

Ph:		Fax:		Email:	
Are there family members that are important to the client that they would like involved as part of their treatment planning or aftercare planning?				☐ Yes	☐ No
If yes, please provide details below:					

Current housing

Housing Type:	☐ Own home/rental ☐ Shelter ☐ No fixed address ☐ With family/friends ☐ Subsidized housing ☐ Other:	Stable: ☐ Yes ☐ No	Safe: ☐ Yes ☐ No

Will the housing be maintained for duration of treatment? ☐ Yes ☐ No

If no, provide details:

Is there a post-discharge housing plan?	☐ Yes ☐ No	Stability:	☐ Yes ☐ No	Safe:	☐ Yes ☐ No

Please describe actions taken to address post discharge housing:

Client strengths

Treatment goals

This section should be completed in collaboration with the client and their community support team

How can the client be best supported with their treatment goals while in program?

Is there any additional information that should be provided at this time?

Substance use and other process issues/concerns

	Client has used/has a history with	Select top three drugs of choice	Current Pattern	Date last used	# Days used in last 30 days	Route taken	Average amount used daily	Age at first use
☐	Alcohol							
☐	Non-beverage alcohol							
☐	Amphetamines							
☐	Ecstasy							
☐	GHB							
☐	Benzo							
☐	Cannabis							
☐	Cocaine							
☐	Crack cocaine							
☐	Crystal meth							
☐	Fentanyl							
☐	Hallucinogens							
☐	Heroin							
☐	Inhalants							
☐	Other opioids							
☐	Tobacco/Nicotine (incl. vaping / e-cigs)							
☐	Other (specify):							

Process addictions

Client has current/history with		Current pattern	Date last active	# Days active last 30 days	Age at first use
☐	Gambling				
☐	Sexual activity				
☐	Pornography				
☐	Shopping				
☐	Shoplifting				
☐	Internet				
☐	Gaming				
☐	Social Media				

Substance use treatment history

☐	Withdrawal management/detox/stabilization	Dates:	
☐	Peer support groups (AA/NA/Smart Recovery)	Dates:	
☐	Community counsellor/social worker support	Dates:	
☐	Substance-use treatment programs *(provide details below)*		

Program:		Date range:		Completed?	☐ Yes ☐ No
Program:		Date range:		Completed?	☐ Yes ☐ No
Program:		Date range:		Completed?	☐ Yes ☐ No

Other: (please provide details)

Why is this program being considered at this time? Please describe clinical reasons if a gender specific program has been selected or describe other complex care needs for the client.

Withdrawal history

Withdrawal management prior to admission needed?	☐Yes ☐No	*If yes, please make arrangements when contacted by BCCH*

History of adverse events while in withdrawal? (e.g. seizures)	☐Yes ☐ No	Date of Last Seizure:	

Delirium Tremens?	☐ Yes ☐ No	Hospital admissions for withdrawal?	☐Yes ☐ No

Please provide any other information that the client feels would be relevant to support them below:

Medical history

Environmental, food, medication allergies?	☐Yes ☐ No

If yes, provide a brief description and type of reaction(s) and treatment needed

Independent with Activities of Daily Living (ADLs)?	☐Yes ☐No	If no, provide details:	

Pregnant?	☐ Yes ☐ No	If yes, estimated date of delivery:	

Past overdose history?	☐ Yes ☐ No	If yes: ☐ Intentional ☐ Accidental	Date/s:

Does the client have a history of disordered eating?	☐ Yes	☐ No	Is the disordered eating still active?	☐ Yes	☐ No

If yes, provide details:		Date last active:	

Has the client ever participated in treatment for disordered eating?	☐ Yes	☐ No	

Medical dietary concerns?	☐ Yes	☐ No	Does the client have any dietary requirements?	☐ Yes	☐ No

Please note concerns and requirements here:

Mobility issues?	☐ Yes	☐ No	If yes, please indicate if any ability aids are being used below:

Fall risk:	☐ Yes	☐ No	HIV:	☐ Yes	☐ No	Hep C:	☐ Yes	☐ No	☐ Unknown

Visual impairment:	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Head injury:	☐ Yes	☐ No	☐ Unknown
Hearing impairment:	☐ Yes	☐ No	Complex cognitive challenges:				☐ Yes	☐ No	☐ Unknown
Other:									

If yes to any of the above, provide details:

Does the client have any scheduled surgeries, dental appointments or specialist appointments?	☐ Yes	☐ No

If yes, provide details:

DSM V diagnosis / Mental health history

Psychiatric diagnoses (Axis I):

Personality disorders & developmental disabilities (Axis II).
Note: For head/brain injury/FASD or cognitive impairment: provide a brief description of cognitive disabilities & attach any collateral assessment/reports (e.g. most recent assessment(s) from psychiatry, O.T., psychology etc.)

Medical illness (Axis III)

Psychosocial and environmental concerns (Axis IV):

Is client connected to Community Living BC or other support workers/services?

☐ Yes ☐ No

Contact Person:		Ph:	

If yes, provide a brief description of the supports and number of hours provided:

Current medication(s)

Please attach a list of medication such as a Pharmanet print-out, copy of prescriptions, Medication Administration Record (MAR) or write the information below

Medication & dose	Date started	Prescriber	Medication & dose	Date started	Prescriber

Currently on ARV treatment?	☐ Yes	☐ No	Have ARV medications been ordered for treatment?	☐ Yes	☐ No
Currently on long acting injectable antipsychotic medication?	☐ Yes	☐ No	Date of next required dose:		

Safety concerns

Self-harming behaviours?	☐Yes ☐No	Suicide ideation?	☐ Yes ☐ No	Flight risk?	☐ Yes ☐ No
Sex work?	☐Yes ☐No	Sexual offences involving minors?	☐ Yes ☐ No		
Arson/Fire setting?	☐Yes ☐No	Interpersonal/Domestic violence?	☐ Yes ☐ No		
Suicide attempt/s?	☐ Yes ☐ No	Dates of attempt/s: (please list all dates)			

<u>If yes to any of the above, please provide detailed information about the safety concern and if possible, provide a copy of the safety plan.</u>
Also please provide the date & circumstances of most recent incident for each one

History of aggression?	☐ Yes	☐ No	If Yes ☐ Verbal ☐ Physical

Please provide a brief description of history of verbal and/or physical aggression incidents, outcomes and date of last occurrence (e.g. throwing objects, hitting someone, yelling, under the influence of substances).

Effective Intervention(s):

Legal

Is the client supervised by a probation officer?	☐ Yes ☐ No	Is the client currently out on bail?	☐ Yes ☐ No
Bail/Probation Officer's contact name:		Ph:	
Are there any conditions that we need to be aware of to support client's stay?			☐ Yes ☐ No
Can client be supported in program in reference to recent/past charges?			☐ Yes ☐ No
Please provide details below:			

Upcoming court date/s:	
Location:	
Please provide details (e.g. transportation required, technological requirements, etc.):	

Status under the BC Mental Health Act	☐	Certified - Please attach a complete set of Form 4's and Form 6's	☐	Voluntary
	☐	Extended Leave – Please attach all Forms 4,6, & 20		

Early exit transition plan

An early exit is when a client leaves treatment prior to treatment completion. In this event, our goal is for the client to have a safe place to go in their home community with appropriate supports. If the client leaves on short notice, or an unplanned urgent discharge is required, the **case manager and the emergency contact will be notified immediately** and the client will be discharged to the location listed below.

Client Name:			
Key community contact for transition plan (name/relationship):			
Ph:		Email:	
Emergency contact and/or next of kin (name/relationship):			
Ph:		Email:	
Community/Health Authority contact (name/agency):			
Ph:		Email:	

Early exit discharge plan

Early exit location contact name:		Relationship:	
Early exit location address:		Location Ph:	
If early exit is home with family, are they aware?		☐ Yes	☐ No
Early exit transportation:			

If no, who will transport? (name, phone, relationship):		
Is this early exit plan the same for the weekend?	☐ Yes	☐ No If no, please provide an alternative plan below:

Signatures

By signing below, I consent to following:

- This referral is being submitted for consideration for a BC Children's Hospital Substance Use Services treatment program
- The information in this referral and any supporting documentation being released and shared between my community care team, regional health authority representatives, BC Children's Hospital representatives and BC Children's Hospital contracted service providers is correct to the best of my knowledge
- Should I choose to leave the program early, my community care team, regional health authority liaison, BC Children's Hospital representatives and BC Children's Hospital contracted service providers, and my emergency contact will be contacted and provided with an update
- My community team and physician will be sent a discharge summary

Client name (PRINT):	
Client signature:	Date (**D/M/Y**):
Case Manager agrees to collaborate with the client to ensure they reconnect with their community services upon discharge within the Health Authority that this referral was originated.	
Case manager name (PRINT):	
Case manager signature:	Date (**D/M/Y**):