Referral for Provincial Youth and Young Adult Treatment Programs

All referrals must be completed by a referring agent in collaboration with the client. A referring agent can be a counsellor, social worker, physician, psychiatrist, community mental health and addiction team provider, psychologist, nurse practitioner, or case manager.

Referral Date		**Patient Legal Name**		**Preferred Name**	
Re-Application or Re-Admit?	☐ Yes ☐ No	**Health Authority**		**FNHA involved?**	☐ Yes ☐ No

Client Information			
Program Requested	☐Coast ☐Phoenix	**Date of Birth** (M/D/Y)	
Care Card Number		Age	

Current Address Must be BC resident	Address incl. postal code:	Phone:	Email:
Gender and Pronoun	☐ Female ☐ Transgender ☐Two Spirit ☐She ☐He ☐They ☐ Male ☐ Non-Binary ☐ Questioning ☐Prefer not to answer		

Community Care Team Information				
Referring Organization		Email:	Phone:	Fax:
Key Community Contact /Case Manager		Email:	Cell:	Home:
Physician Name		Clinic Name:	Clinic Location:	Phone:
Psychiatrist Name		Clinic Name:	Clinic Location:	Phone:
Community Pharmacy		Location	Phone	Phone:

Income and Medical Pharmacy Coverage		
Income Source	☐ MSDPR ☐ PWD ☐ Employment Insurance ☐ Long Term Disability ☐ CPP/CPPD ☐ Employed ☐ Other Income	
Medical/Pharmacy Coverage Type	Policy Number: ID Number:	Third Party Insurer:

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	Predominantly lives: ☐ both on and off reserve ☐ Off Reserve ☐ On Reserve ☐ No Response
	Indigenous Identity Group: ☐ First Nations ☐ First Nations & Inuit ☐ First Nations & Metis ☐ Inuit ☐ Metis ☐ First Nations & Metis & Inuit ☐ Metis & Inuit ☐ Outside of Canada ☐ unknown ☐ no response	First Nations Status: ☐ Has Status ☐ Non Status ☐ Pending Status ☐ No response
	Metis Citizenship ☐ Has citizenship ☐ If yes, Citizenship # ☐ Non-Citizenship ☐ Pending Citizenship ☐ No Response	Status Card Number: Band :
Ethnicity:	Primary Language:	Interpreter Needed? ☐ Yes ☐ No Provide details:

Emergency Contact Person/Substitute Decision Maker/Power of Attorney				
Emergency Contact Support Person	Name:	Relationship:	Phone:	Email:
Is there a Substitute Decision Maker?	☐ Yes ☐ No	Name:	Phone:	Email:
Is there a Power of Attorney in place?	☐ Yes ☐ No If yes, please provide a brief Description: (eg. Finances, treatment decisions, etc.)			
Is there a Trustee?	☐ Yes ☐ No	Name:	Phone:	Email:
Family Involvement				
Does the client have children?	☐ Yes ☐ No	Number of Children:	Ages:	
Are children in Foster Care?	☐ Yes ☐ No			
Is client a custodial parent?	☐ Yes ☐ No	Name of Custodial/Foster Parent(s):	Phone:	Email:
If Applicable, what is the children's current living situation?				
If Applicable, what visit(s) are available for the client with their children?				
If Applicable, provide details for visits including Ministry of Children and Family Development contact information:		Phone:	Fax:	Email:
IMPORTANT FAMILY MEMBERS	Are there Family Members who are important for the client to have involved in treatment planning and after care planning? ☐ Yes ☐ No		If yes, please provide details:	
Client Strengths				

Treatment Goals (please complete in collaboration with client)

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

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

_____

_____

_____

_____

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.

_____

_____

_____

_____

_____

_____

Are there regional resources that would meet this person's needs?

☐ Yes ☐ No Please offer details:

_____

_____

_____

_____

_____

What barriers exist in accessing appropriate resources and can these be resolved within the regional resources?
Eg. Mental health needs are too high, behaviours can not be managed, person has been barred from service

_____

_____

_____

_____

Please identify any anticipated challenges and identify any supports needed for success in the program.

_____

_____

_____

_____

Current Housing:

Housing Type:	Stability:	Will housing be maintained for duration of treatment? ☐ Yes ☐ No
☐ Own home/Rental ☐ Shelter ☐ No Fixed Address ☐ Subsidized Housing ☐ With Family/Friends ☐ Other _____	☐ Yes ☐ No Safe: ☐ Yes ☐ No	If no please provide details: _____ _____

Post Discharge Housing:

Is there a post discharge housing plan?	If no, please describe actions taken to address post discharge housing:	Stability:	
☐ Yes ☐ No	_____ _____	☐ Yes ☐ No Safe: ☐ Yes ☐ No	

Substance Use

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 Issues/Concerns

Client has used/has a history with:	Current Pattern	Date Last Active	# Days active in 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	Date Range(s):		Completed? ☐ Yes ☐ No
	Program(s):		
	Date Range(s):		Completed? ☐ Yes ☐ No

Peer Support Groups (AA/NA/Smart Recovery)	Program(s):		
Community Counsellors/Social Worker Support	Date Range(s):		Completed? ☐ Yes ☐ No
	Program(s):		
Substance Use Treatment Programs	Date Range(s):		Completed? ☐ Yes ☐ No
	Program(s):		
Other:	Date Range(s):		Completed? ☐ Yes ☐ No
	Program(s):		
Please provide details of what worked well, and what did not work well in previous treatment program experience?			

Withdrawal History		
Withdrawal Management/Detox Stabilization required prior to admission?	☐ Yes ☐ No	If yes, please have plan of care ready when contacted by BCCH
Is RAAC (Rapid Access Addiction Clinic) Assessment needed?	☐ Yes ☐ No	
History of Adverse Events while in withdrawal? (eg. Seizures):	☐ Yes ☐ No	Date of Last Seizure:
Delirium Tremens?	☐ Yes ☐ No	If yes, provide details:
Hospital Admissions for Withdrawal?	☐ Yes ☐ No	If yes, provide details:

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

Medical History	
Allergies: Environmental, food, and/or medication?	☐ 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 /Expecting a child?				☐ Yes ☐ No If yes, please attach any relevant prenatal documents with estimated due date, plan of care, and care provider(s).	
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:			
Has the client participated in treatment for disordered eating?	☐ Yes ☐ No If yes, provide details:				
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:			
Fall Risk:	☐ Yes ☐ No	**Visual Impairment:**	☐ Yes ☐ No	**Hearing Impairment:**	☐ Yes ☐ No
Prothesis:	☐ Yes ☐ No	**History of Head Injury:**	☐ Yes ☐ No	**Complex Cognitive Challenges:**	☐ Yes ☐ No

Other:
If yes to any of the above, please provide details:

DSM V Diagnosis /Mental Health History

Psychiatric Diagnosis (Axis I)

Personality Disorders and Developmental Disabilities (Axis II)

Note: For head/brain injury/FASD or cognitive impairment: Provide a brief description of cognitive disabilities and attach any collateral assessment/reports (eg. Most recent assessment(s) from psychiatry, OT, 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: Phone:

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

CURRENT MEDICATIONS

Please attach a list of medications

(eg. 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

Hepatitis C?	☐ Yes ☐ No ☐ Unknown	**HIV?**	☐ Yes ☐ No
Currently on Antiretroviral (ARV) Therapy	☐ Yes ☐ No	**Have ARVs been ordered for treatment?**	☐ Yes ☐ No
Currently on long acting injectable anti-psychotic medication?	☐ Yes ☐ No	Date of next required dose:	

SAFETY ASSESSMENT AND PLAN OF CARE

PLEASE FILL OUT A SAFETY PLAN IF YES TO ANY OF THE BELOW

Self Harm Behaviours in last year?	☐ Yes ☐ No	If yes, please provide dates of self harm(s) and any situational factors at the time:
Suicidal Ideation in last year?	☐ Yes ☐ No	If yes, please provide dates of suicidal ideation(s) and any situational factors at the time:
Suicide Attempt in last year?	☐ Yes ☐ No	If yes, please provide ALL dates of suicide attempt(s) and any situational factors at the time of attempt:

SAFETY PLAN PLEASE FILL OUT IN COLLABORATION WITH THE CLIENT IF YES TO ANY OF THE ABOVE	
What are some things that make you feel stressed or unsafe? Eg. Crowds, loud noises, thoughts, self or other's expectations, seeing drugs	
What Early Warning Signs do you notice when you begin to feel stressed or unsafe? Eg. Cutting, raised voices, thinking about hurting self, self-isolate	

What can I do by myself to make sure I feel safe?	
1.	

2.	
3.	
4.	

What are some ways that supportive people can help me feel safe?

1.	
2.	
3.	
4.	

What are your strengths that you can use to help you feel better?
Think about what you have done in the past to feel better:
Eg. Yoga, Box breathing, going outdoors, having a shower, exercising

1.	
2.	
3.	
4.	

VIOLENCE AND RISK ASSESSMENT
PLEASE FILL OUT AN ACTION PLAN IF YES TO ANY OF THE BELOW

Interpersonal and/or Domestic Violence in last year to others?	☐ Yes ☐ No
History of Physical and/or Verbal Aggression in last year ?	☐ Yes ☐ No
Please provide a brief description of history of verbal and/or physical aggression incident(s), outcomes, and dates of last occurrence. Was the incident under the influence of substances?	
Were there any effective intervention(s)?	

ACTION PLAN
PLEASE FILL OUT IN COLLABORATION WITH THE CLIENT IF YES TO ANY OF THE ABOVE

How has anger interfered with your life?
Eg. Throwing things, saying hurtful things, threatening or hurting others

How do you know when you are starting to feel aggressive or angry? Eg. Signs can be clenched jaw, tightened fist, raised voice, or other physical signs of anger
What has worked for you in the past to cool down? Eg. Go for a walk, play basketball/soccer, journal
How can others support you? Eg. Leave me alone, give me space, go for a walk

Sexual Offence(s) involving minors	☐ Yes ☐ No Please provide dates/details and circumstances for most recent incident:
Arson/Fire Setting?	☐ Yes ☐ No Please provide dates/details and circumstances for most recent incident:

LEGAL			
Is client supervised by a probation officer?	☐ Yes ☐ No	**Is client currently out on bail?**	☐ Yes ☐ No
Bail/Probation Officer Name		Phone:	

Are there any legal conditions that we need to be aware of to support client's stay?			☐ Yes ☐ No *If yes, please provide details:*		
Can client be supported in program in reference to recent/past charges?			☐ Yes ☐ No *If yes, please provide details:*		
Upcoming Court Date(s):		Location:		Transportation Required? Or other technological requirements	
Status under the BC Mental Health Act	☐ Certified Please attach a complete set of Form 4's and Form 6's ☐ Extended Leave – Please attach all Forms 4, 6, and 20 ☐ Voluntary				

EARLY EXIT PLAN (EEP)

An early exit plan is when a client leaves treatment prior to completion. If a client leaves on short notice, or an unplanned urgent discharge is required, the key community contact/case manager AND the emergency contact person will be notified immediately, and the client will be discharged to the below:

Emergency Contact Person (Family/Friend/Support Person) This person should be contacted should there be an emergency concern about safety, medical, etc. Please ensure this person is aware and agrees to the plan	**Name (First and Last):**	**Relationship to client:**	**Phone:**	**Email:**
Early Exit Plan Location	**Address:**	**Phone:**	**If early exit is home with family, are they aware? If no, how do you plan to support?**	☐ Yes ☐ No
Early Exit Transportation	**Name:**	**Relationship:**	**Phone:**	
Is EEP (location and transportation) the same on weekends and evenings?	☐ Yes ☐ No	**If no, please list alternative EEP location and transport:**		

Provincial Substance Use Treatment Program
Client Participation Agreement Form

As part of my treatment application, I have reviewed the program services and I understand that this is an abstinence-based program. Upon arrival and admission to the Provincial Substance Use Treatment Program (PSUTP), I agree with the following:

- A physical examination with physician and nurses and participating in medical review/assessments
- Will provide all prescription and non-prescription medications to the nurse
- If recommended, meeting with the Program Psychiatrist
- Participating with the bed-bug protocol, which includes showering and washing my clothing

On an ongoing basis I understand and agree the following:

- Participating in group and individual counselling programs
- Working with the Treatment Team to plan my successful return home after treatment
- Treating others with respect, dignity and without discrimination
- Participating in assessment and development of a treatment plan and committing to following this plan
- Following program guidelines
- Working towards abstinence from smoking by participating in cessation programs
- Abstaining from all drugs, alcohol and over-the-counter and pharmaceuticals (with the exception of prescribed medications)
- Recognizing that the Program is scent-free
- Will only leave the Program area when planned and with staff
- Will visit with family and supports during visiting hours
- Understand that for reasons of confidentiality, I may need to leave my cell phones, cameras, Ipods or personal data devices at home.
- Will keep all information about other program participants confidential
- Understand that I may be required to share a room with another client
- Understand that I will need to keep food items in designated areas and not in my room
- Understand that for safety and comfort, I will keep my room clean and clutter-free
- Understand that for safety, comfort and respect of my roommates, I will not invite others to my room
- Understand that for safety, staff may conduct random room searches
- Understand that I need to take all my belongings with me when I leave the Program and that anything I do not take with me will be donated to charity
- Understand that aggressive behaviours and recruiting others into gangs or sex-trade may result in being asked to leave the program

Confidentiality is an extremely important matter in the Program. In serving you, the Program will work to appreciate your situation and how we can best support you. Just as with any health service, some of what we learn about you will be recorded in electronic/paper files. We record these details for the following three main reasons:
1. To support good planning and delivery of service to you. This involves sharing information between program staff and key professionals involved in helping you.

2. To provide necessary information for activity reports (e.g., how many people we serve, ages, needs). Activity reports information is important for service planning and is used by the Program and shared with health authorities. Activity reports do not contain the names of people we serve.
3. Audits, service reviews, follow-ups or quality assurance surveys require access to contact and other personal information. These audits, reviews, follow-ups and surveys are conducted by the Program, an accrediting body or the funder. This helps ensure that we are doing a good job and it provides opportunities to learn from the people we serve towards improving services.

Apart from the four basic exceptions (below), this information will not be shared with anyone outside of PSUTP unless you give us written permission to do so.

These **four basic exceptions** are:
1. If there is a concern related to the safety and wellbeing of any one currently less than 19 years of age (e.g., neglect or abuse of a child), Ministry of Children and Family Development and/or the police may need to be contacted. This is about protecting children.
2. If there is a concern that you may harm yourself, another person or the public.
3. If you are experiencing a medical emergency.
4. If there is a legally authorized request, enquiry, investigation or duty to report.
For example, a subpoena, warrant or other type of court order; required report related to Communicable Disease Regulations; an investigation by Worker's Compensation Bureau; an investigation conducted by the Coroners Service of British Columbia.

If you have any questions or concerns about the limits of confidentiality, you are encouraged to speak with your counsellor / health care practitioner. PSUTP is committed to being as open as possible about our responsibilities to both you and the community.

Please indicate below your consent for PSUTP to share your personal information.

Name	Phone Number/Email	Specify limitations to the information you consent to
Counsellor		
Physician		
Psychiatrist		
Social Worker		
Probation Officer		
MCFD Worker		
Other		

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.

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

I agree to both the client participation agreement and the consent to release of information as specified above.

I have carefully reviewed the above information and any questions or concerns have been addressed to my complete satisfaction.

By signing below, I consent to my referral liaison and emergency contact being contacted.
I also understand that if I leave PSUTP early, my physician will be sent an early discharge summary.

Client Name:		**Signature:**		**Date:**	
Parent/Guardian Name:		**Signature:**		**Date:**	
Referral Agent agrees to the repatriation of the client upon discharge from the treatment program.					
Referral Agent / Case Manager Name:		**Signature:**		**Date:**	