TURNING POINT RECOVERY SOCIETY REFERRAL PACKAGE

Please FAX completed form to the site you are referring to.

GENERAL INFORMATION

Client name: Referral Date:

Date of Referral:

____(DD)/____(MM)/____(YYYY)

Date of Birth: ____(DD)/____(MM)/____(YYYY)

Age:_____

Client's Community Health Authority:

___Vancouver Coastal Health ___ Interior Health ___ Fraser Health ___ Northern Health ___ Island Health

Program You are Referring To:

Vancouver Men's: ___ Women's: ___	**FAX: 604-874-5752**	**PH: 604-875-1710**
Richmond Men's: ___	**FAX: 604-303-7646**	**PH: 604-303-6717**
Richmond Women's: ___	**FAX: 604-284-5421**	**PH: 604-284-5354**
North Vancouver Women's: ___	**FAX: 604-973-0151**	**PH: 604-971-0111**
North Vancouver Men's (opening January 2017): ___	**FAX: c/o 604-973-0151**	**PH: c/o 604-971-0111**

Note: Trans people are welcome at *all sites.*

Who is making the referral?

Name:_____

Agency Name: _____

Role:_____

Phone #:_____Email:_____ Fax #: _____

How many sessions have you had with the client? ___

Will you continue to support your client through and after their stay at the STLR or Treatment Facility? Yes O No O

CLIENT INFORMATION

Legal Name:		
Preferred Name(s):		
Social Insurance Number:		Personal Health Number (PHN):
Street Address:		
City:	Province:	Postal Code:
Telephone:	Okay to leave a message? Yes No	Email:

CLIENT INFORMATION - CONTINUED

Client name: Referral Date:

Emergency Contact Information:

Name: Relationship: Phone:

Can we contact this person if you are discharged early from Turning Point? Yes ____ No ____

If not, is there another individual we can contact in this situation?

Do you have any children under 19? Yes ___ No ___ Are they living with you? Yes ___ No ___

Is MCFD involved? Yes ___ No ___ Please provide additional info, if necessary:

CULTURAL INFORMATION

We invite you to let us know if there are any traditional practices or ceremonies that will support your wellness while at Turning Point

Is there anything you would like us to know that we have not included here about you or your culture?

Do you identify yourself as an Aboriginal person that is First Nations, Metis or Inuit? Yes ___ No ___

If you identify as an Aboriginal person, are you: First Nations ____ Metis ____ Inuit ____

Status: Yes ___ No ___ Band:

CLIENT'S STRENGHTS, INTERESTS, HOPES

Tell us about your strengths and positive qualities:

Tell us about your interests, talents and passions:

Tell us about your hopes for treatment:

SUBSTANCE USE TREATMENT HISTORY

Client name: Referral Date:

Have you completed a withdrawal management program (including home detox, daytox)? Yes ___ No ___

If yes, please list most recent dates, where, and for what substances:

Have you ever participated in substance use services and supports (including counsellor, outpatient clinic, AA, NA, etc)? Yes ___ No ___

If yes, please list most recent dates, where, and what substances you were using at the time:

What has been helpful in your past recovery or support experiences?

What has been unhelpful in your past treatment or support experiences?

GENDER AND SEXUAL ORIENTATION

Turning Point provides gender-separated services. Respectful of gender diversity, we will work with you to figure out how to provide services in the setting that respectfully treats you according to your self- identified gender and sexual orientation. Gender is diverse and we invite you to let us know what gender you identify with:

Male Female Gender Creative/Fluid Transgender: MTF FTM Other:_____Prefer not to answer

What pronoun would you like us to use? He She They Other: _____

Sexual orientation is diverse and we invite you to let us know your sexual orientation:

Heterosexual Lesbian Gay Bisexual Queer Questioning
Two-Spirit Pansexual Asexual Other:_____Prefer not to answer

Is your reason for getting help (substance use, mental health concerns) related to any issues around your sexual orientation or gender identity?

Not at all A little Somewhat A lot Unsure Prefer not to answer

SUBSTANCE USE

Client name: Referral Date:

Primary Problem (Yes/No)	Substance	Primary Route of use (Oral, nasal, Sublingual, smokE inhale, anal, intravenous, intra muscular, transbuccal)	# days used in last	Amount Used in a Typical Day	Age at First Use	Current Use	Stage of Change
	Alcohol						
	Non-Beverage Alcohol						
	Tobacco						
	Cannabis						
	Crack Cocaine						
	Cocaine						
	Heroin						
	Opiates						
	Opiates						
	Benzos						
	Crystal Meth						
	Amphetamines						
	Club Drugs						
	Hallucinogens						
	Inhalants						
	Over the Counter						
	Other Rx Meds						
	Other						

Client name:	Referral Date:

Have you ever accidentally overdosed? Yes ___ No ___

If yes, please tell us briefly about the most recent date this happened:

OTHER PROBLEMATIC BEHAVIOURS

Do you or anyone in your life have concerns that you might have problems with any of the following behaviours (that is, you spend a lot of time, spend more money than you intended and/or it's interfering with other responsibilities)?

	Yes	No	Hours per day/Days per month
Shopping			
Sexual activity			
Gambling			
Pornography			
Other (Internet Overuse, Shoplifting, Theft, or _____)			

CLIENT'S HEALTH

Last TB Test (Date):
Attach results with this form (Chest x-ray, Mantoux skin test)

Are you pregnant? Yes ___ No ___Unsure ___ N/A ___	Number of weeks pregnant:
Do you have a history of seizures? Yes ___ No ___	Date of last seizure:

If yes, please let us know the cause of the seizures, if known (substance use related?):

Do you have any of the following, ongoing, health conditions?

Asthma ___ breathing problems ___ heart problems ___ circulatory issues ___ stomach problems ___

Do you take medication for these conditions? If so, what?

Do you have diabetes? Yes ____No ____ If yes, is it managed with meds? Yes ___No ___

Do you have any allergies? Yes ____No ____ What is required to manage your allergies?

Do you require an epi-pen for allergies? Yes ____No ____

Client name:	Referral Date:

Do you have any special dietary needs? Yes ____No ____ If yes, please describe:

Do you have any mobility issues? Yes ____No ____

Do you use a walker? Yes ____No ____ Or a wheelchair? Yes ____No ____

If yes, please tell us briefly about your mobility concerns/needs:

MENTAL HEALTH

Do you have any mental health concerns? Yes ____No ____

What are your concerns?

Have you received a mental health diagnosis? Yes ____No ____ If yes, please elaborate:

Are you on medications for mental health concerns? Yes ____No ____

What medication are you on?

Is this medication helpful? Yes ____No ____ Please comment:

When was the last time you had significant problems with…

1. Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?
   Past month ____ 2-3 mo's ago ____ 4-12 mo's ago ____ 1+year ago ____ Never ____
2. Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?
   Past month ____ 2-3 mo's ago ____ 4-12 mo's ago ____ 1+year ago ____ Never ____
   Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?
   Past month ____ 2-3 mo's ago ____ 4-12 mo's ago ____ 1+year ago ____ Never ____
3. Becoming very distressed and upset when something reminded you of the past?
   Past month ____ 2-3 mo's ago ____ 4-12 mo's ago ____ 1+year ago ____ Never ____
4. Seeing or hearing things that no one else could see or hear, or feeling that someone else could read or control your thoughts?
   Past month ____ 2-3 mo's ago ____ 4-12 mo's ago ____ 1+year ago ____ Never ____

Client name:	Referral Date:

MENTAL HEALTH – CONTINUED

Do you have any history of disordered eating? Yes ____No ____If yes, please elaborate:

Binging ___ Purging ___ Restricting ___ Laxatives ___ Excessive exercising ___ Other, please describe:

Have you ever participated in treatment for disordered eating? Yes ____No ____

If yes, please tell us briefly about this:

Is the disordered eating still active? Yes ____ No ____	If no, when was it last active?

Do you engage in self-harming behaviours (cutting, burning, scratching)? Yes ____No ____
If yes, is self-harm currently active? Yes ____No ____ Please comment:

Do you have thoughts of killing yourself (committing suicide)? Yes ____No ____Not Assessed

If yes, do you have a current plan for suicide? Yes ____No ____If yes, please elaborate:

Have you ever attempted suicide? Yes ____No ____
If yes, date of most recent attempt:

Have you experienced a head injury or head trauma Yes ____No ____ If yes, please tell us briefly about current head injury related concerns:

Do you often feel confused or overwhelmed in new places? Yes ____No ____If yes, please tell us more information about this:

Client name: Referral Date:

CURRENT MEDICATIONS

Note: We will search Pharmanet for a list of your current medications. A consent form is attached (see page 18).

Do you have any concerns about your current medications?

Are you on current opiate maintenance therapy? Yes ____No ____Which therapy?

Who is your care provider?

Start Date: Current Dose:

Current Opiate Maintenance Therapy Details:

PSYCHOLOGICAL & SOCIAL

Have you ever experienced problems controlling your anger / aggression? Yes ____No ____If yes, please tell us briefly about any anger or aggression concerns that are current or in the recent past:

Are you currently experiencing violence? Yes ___No ___Have you experienced violence in the past? Yes ___No ___
If yes, please tell us briefly about any concerns related to your current safety:

Do you have concerns for your safety related to your care in the program? Yes ____No ____. Please elaborate:

Do you have safety concerns related to aftercare? Yes ____No ____. Please elaborate:

Do you have any concerns about being in a group setting/environment? Yes ____No ____. Please elaborate:

Client name: Referral Date:

HOUSING

What is your current housing situation?

Is your current housing situation: Safe ____ Unsafe ____ ?

Details:

Do you need help with a housing plan? Yes Yes ____No ____.

LEGAL CIRCUMSTANCES

Do you have any upcoming court dates? Yes ____No ____.

If yes, when and where (please attach more information if needed):

Are you on probation or parole? Yes ____No ____.

Do you have a conditional sentence? Yes ____No ____. Charges? Yes ____No ____.

If yes to any of the above, please provide contact information on consent form.

FINANCIAL CIRCUMSTANCES

What is your funding source for the STLR or Treatment Facility stay?

Income Assistance PWD Accommodation Fee Subsidy Other_____

Have you applied for Income Assistance? Yes ____No ____I don't know ____
If yes, application #_____

Do you have an open file with MSDSI? Yes ____No ____I don't know ____

Client name:	Referral Date:

CONSENT FOR RELEASE OF INFORMATION

Please indicate below your consent for Turning Point staff to share your personal information with the following individuals:

SERVICE PROVIDER	NAME	TELEPHONE # (include extensions)	Specify any limitations to the information you consent to share
Probation or Parole Officer			
Lawyer			
Other			
Other			

CLIENT AUTHORIZATION

I, _____ (full name) have reviewed the information in the Privacy and Consent section (on page 14). I consent to the release of information as specified above (if applicable).

PRINTED NAME _____ SIGNATURE_____

DATE: ____(DD)/_____(MM)/_____(YYYY)

WITNESS:

PRINTED NAME _____ SIGNATURE_____

RELATIONSHIP_____ DATE: ____(DD)/_____(MM)/_____ (YYYY)

Turning Point collects, uses, and shares personal information only in accordance with the *BC Freedom of Information and Protection of Privacy Act*

Client name:	Referral Date:

PARTICIPANT AGREEMENT

I,_____, (full name) have reviewed the referral information and *Client Considerations* section. I agree to voluntarily apply for services with Turning Point.

I agree while I am in the program I will:

___ treat others with respect and dignity and without discrimination

___ honour the privacy and right to confidentiality of others

I agree to participate in the following activities upon arrival at the STLR:

___ medical assessment with the program doctors and nurses

___ medication review including handing in all medications to the program staff

___ urine sample and breathalyzer, if requested

___ review of your personal belongings in your presence

___ program orientation with staff

SIGNATURE_____

PRINTED NAME _____ DATE:_____ (DD)/_____(MM)/_____(YYYY)

COMMUNITY COUNSELLOR/HEALTH CARE PROFESSIONAL:

SIGNATURE_____

PRINTED NAME _____ DATE: _____(DD)/_____(MM)/_____(YYYY)

CONTACT NUMBERS AND FAX

Turning Point Vancouver: 604-875-1710 FAX: 604-874-5752

Turning Point Richmond Men's: 604-303-6717 FAX: 604-303-7646

Turning Point Richmond Women's: 604-284-5354 FAX: 604-284-5421

Turning Point North Shore Women's: 604-971-0111 FAX: 604-973-0151

Turning Point North Shore Men's: c/o 604-971-0111 (to open January 2017)
FAX: c/o: FAX: 604-973-0151

Client name:	Referral Date:

EARLY EXIT TRANSITION PLAN

Should I leave Turning Point prior to program completion, **I agree to utilize the support of the staff for resource information, and safe exit/transition planning and**:

O Return to my home and/or the home of the individual named below for immediate shelter and transition support;

and/or

O Contact the agency/worker named below for immediate shelter and transition support.

EARLY EXIT CONTACTS:

1) Name_____Relationship_____
   Home #:_____Cell #: _____

2) Name_____Relationship_____
   Home #:_____Cell #: _____

3) Organization/Agency Name:_____ Contact/Workers Name_____
   Phone #:_____ Cell #:_____

SIGNATURE_____

PRINTED NAME _____ DATE:_____ (DD)/_____(MM)/_____(YYYY)

COMMUNITY COUNSELLOR/HEALTH CARE PROFESSIONAL:

SIGNATURE_____

PRINTED NAME _____ DATE: _____(DD)/_____(MM)/_____(YYYY)

ADDITIONAL INFORMATION (e.g. details of your Early Exit Transition Plan):

Ministry of Health

Patient Consent for Treatment Providers to Access PharmaNet Information

The Province of British Columbia has established the provincial computerized pharmacy network and database known as "PharmaNet" pursuant to Section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363.

REGARDING:_____
[Patient Name, Please Print]

DOB: PHN#: _____

I,_, [Patient Name, Please Print], authorize access to my personal health information contained within Pharmanet by medical practitioners, pharmacists, and other authorized persons for the purpose of providing therapeutic treatment or care to me in _____ [Facility Name, Please Print] ("the Facility").

If I have a keyword on my medication profile, I will provide the keyword to enable the Facility's access to my PharmaNet information as required. When I am no longer receiving care or treatment from the Facility, the keyword that I have provided will be removed from all records relating to me.

I understand that if I am not able, for any reason, to provide my keyword, and a medical practitioner has reasonable grounds to believe that safe and effective care and treatment cannot be provided without accessing my medication profile, he/she will do so by contacting the PharmaNet Help Desk to have the keyword removed from my profile.

I understand that this consent will expire when I am no longer receiving care or treatment from the Facility. If I wish to withdraw this consent prior to that time, I understand that the withdrawal must be in writing and delivered to the Facility directly.

Signed at_____, British Columbia, this day of_____, 20 .

Patient/Guardian Signature

Witness Signature

Witness Name, Please Print