



TurningPoint

REFERRAL FORM		
NAME:		
	LAST NAME	FIRST NAME
DATE OF REFERRAL:		

SITE:	<input type="checkbox"/> Vancouver	<input type="checkbox"/> Richmond	<input type="checkbox"/> North Shore	<input type="checkbox"/> Squamish
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**PART 1 – PERSONAL INFORMATION**

LEGAL NAME:	OTHER NAMES:
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DATE OF BIRTH:	AGE:
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SOCIAL INSURANCE #:	PERSONAL HEALTH #:
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GENDER IDENTIFICATION:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender Man <input type="checkbox"/> Transgender Woman <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Prefer Not to Say
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CONTACT #1:	CONTACT #2:
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HOUSING STATUS:	<input type="checkbox"/> Homeowner <input type="checkbox"/> Renting <input type="checkbox"/> Homeless <input type="checkbox"/> Staying with Family <input type="checkbox"/> Staying with Friends <input type="checkbox"/> Other _____	CITY/TOWN:
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FINANCIAL STATUS:	<input type="checkbox"/> Employed <input type="checkbox"/> Employment Insurance (EI) <input type="checkbox"/> Pension: _____ <input type="checkbox"/> Income Assistance <i>(please complete Confirmation of Income Form found on our website)</i> <input type="checkbox"/> Other _____
The funding for your stay will be determined based on this information.	

**REFERRING AGENCY INFORMATION**

*Please select the box corresponding to the Health Authority/Agency you're referring from, along with the name of the program.*

<input type="checkbox"/> Vancouver Coastal Health (VCH) – _____
<input type="checkbox"/> Fraser Health (FHA) – _____
<input type="checkbox"/> Island Health (VIHA) – _____
<input type="checkbox"/> Interior Health Authority – _____
<input type="checkbox"/> Northern Health Authority – _____
<input type="checkbox"/> First Nations Health Authority (FNHA) – _____
<input type="checkbox"/> Providence Health Care – _____
<input type="checkbox"/> Other: _____

Completed By:	PHONE NUMBER:
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SIGNATURE:	EMAIL ADDRESS:
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**PART 2 – CURRENT STATUS**

**Current Situation & Areas of Concern**  
(Include crisis details or circumstances leading to treatment)

**Safety Concerns**  
(Include history or current violence in relationships)

**Legal History**  
(Please check all that apply and provide details where necessary)

- No legal issues reported
- Pending court dates:
- Charges:
- Outstanding warrants (Type & Location):
- Probation/Parole (Duration & Conditions):

**CONSENT FOR RELEASE OF LEGAL INFORMATION**

I, \_\_\_\_\_, consent to the release of information by all legal representatives to Turning Point Recovery Society.

Signature: \_\_\_\_\_  
(CLIENT SIGNATURE)

Date: \_\_\_\_\_

DD/MMM/YYYY

**PART 3 – PHYSICAL HEALTH**

**Medical Diagnoses / Major Illnesses**  
(Include any chronic conditions, disabilities, or significant health concerns)

**Current Physical Health Concerns**  
(Include mobility aids or assistive devices used, e.g., hearing aids, walkers, prosthetics)



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Communicable Diseases	Pregnancy Status
(Please check all that apply) <input type="checkbox"/> None Reported <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis A, B, or C <input type="checkbox"/> Other: _____ Last Date Tested: _____	<input type="checkbox"/> None Reported <input type="checkbox"/> Pregnant – Due Date: _____

CURRENT MEDICATIONS		
NAME	CONDITION BEING TREATED	DOSAGE
<input type="checkbox"/> OPIATE REPLACEMENT THERAPY (ORT)		

PART 4 – MENTAL HEALTH
Mental Health Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:  
Self-Harming Behaviours <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:  
Suicide Risk (Please check all that apply) <input type="checkbox"/> Current Risk, <input type="checkbox"/> Past Risk, <input type="checkbox"/> Previous Suicide Attempts Additional details (if applicable):  



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PART 5 – PROBLEMATIC SUBSTANCE USE HISTORY				
SUBSTANCE	PRIMARY ROUTE OF USE (ORAL, NASAL, INHALED, INTRAVENOUS, ETC.)	TYPICAL DAILY AMOUNT	DURATION OF USE (YEARS/MONTHS)	DATE LAST USED
ALCOHOL				
NON-BEVERAGE ALCOHOL				
AMPHETAMINES				
CANNABIS				
COCAINE				
CRACK COCAINE				
CRYSTAL METH				
OPIATES				
OPIATES FENTANYL				
HEROIN				
BENZOS				
INHALANTS				
TOBACCO / NICOTINE				
CLUB DRUGS				
MISUSE OF PRESCRIPTIONS				
OTHER				

OTHER ADDICTIONS OR ADDICTIVE BEHAVIOURS (SEX, FOOD, GAMBLING, ETC.)
DESCRIBE:

PREVIOUS ADDICTION SUPPORT / TREATMENT			
AGENCY NAME	DATE ATTENDED	OUTCOME	COMMENTS



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PART 6 – PROFESSIONALS INVOLVED			
	NAME	AGENCY / OFFICE	TELEPHONE
PHYSICIAN (G.P.)			
PSYCHIATRIST			
MENTAL HEALTH TEAM			
MINISTRY OF CHILDREN & FAMILY DEVELOPMENT (MCFD)			
LAWYER			
PAROLE OFFICER			
OTHER			

PART 7 – CLIENT AUTHORIZATION	
<p>I, _____, verify that the information provided on this form is true to the best of my knowledge. I consent to the release of this information to Turning Point Recovery Society.</p>	
CLIENT SIGNATURE:	DATE:
	DD/MMM/YYYY

INTERNAL USE ONLY			
DATE RECEIVED		WAITLISTED	<input type="checkbox"/> YES <input type="checkbox"/> NO
DATE WAITLISTED			

TP Vancouver	Phone: 604-875-1710	Fax 1-604-874-5752
TP Richmond Mens'	Phone: 604-303-6717	Fax 1-604-303-7646
TP Richmond Womens'	Phone: 604-284-5354	Fax 1-604-284-5421
TP North Shore Womens'	Phone: 604-971-0111	Fax 1-604-973-0151
TP North Shore Mens'	Phone: 604-988-4317	Fax 1-604-988-4317
TP Squamish	Phone: 604-390-0395	Fax 1-604-390-1474