TurningPoint

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

| SITE: | ☐ Vancouver | ☐ Richmond | ☐ North Shore | ☐ Squamish |
|---|---|---|---|---|

## PART 1 – PERSONAL INFORMATION

| | |
|---|---|
| **LEGAL NAME:** | **OTHER NAMES:** |
| **DATE OF BIRTH:** | **AGE:** |
| **SOCIAL INSURANCE #:** | **PERSONAL HEALTH #:** |

**GENDER IDENTIFICATION:**

- ☐ Male
- ☐ Female
- ☐ Non-Binary
- ☐ Transgender Man
- ☐ Transgender Woman
- ☐ Two-Spirit
- ☐ Prefer Not to Say

| | |
|---|---|
| **CONTACT #1:** | **CONTACT #2:** |

**HOUSING STATUS:**

- ☐ Homeowner
- ☐ Renting
- ☐ Homeless
- ☐ Staying with Family
- ☐ Staying with Friends
- ☐ Other_____

**CITY/TOWN:**

**FINANCIAL STATUS:**

**The funding for your stay will be determined based on this information.**

- ☐ Employed
- ☐ Employment Insurance (EI)
- ☐ Pension:_____
- ☐ Income Assistance *(please complete Confirmation of Income Form found on our website)*
- ☐ Other_____

## REFERRING AGENCY INFORMATION

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

- ☐ Vancouver Coastal Health (VCH) – _____
- ☐ Fraser Health (FHA) – _____
- ☐ Island Health (VIHA) – _____
- ☐ Interior Health Authority – _____
- ☐ Northern Health Authority – _____
- ☐ First Nations Health Authority (FNHA) – _____
- ☐ Providence Health Care – _____
- ☐ Other: _____

| | |
|---|---|
| **Completed By:** | **PHONE NUMBER:** |
| **SIGNATURE:** | **EMAIL ADDRESS:** |

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|---|---|---|
| NAME: | | |
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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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|---|---|---|
| NAME: | | |
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**Communicable Diseases**

(Please check all that apply)

- ☐ None Reported
- ☐ Tuberculosis (TB)
- ☐ HIV
- ☐ Hepatitis A, B, or C
- ☐ Other: _____

Last Date Tested: _____

**Pregnancy Status**

- ☐ None Reported
- ☐ Pregnant – Due Date: _____

| CURRENT MEDICATIONS | | |
|---|---|---|
| NAME | CONDITION BEING TREATED | DOSAGE |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ OPIATE REPLACEMENT THERAPY (ORT)

**PART 4 – MENTAL HEALTH**

Mental Health Diagnosis ☐ Yes ☐ No If yes, please describe:

Self-Harming Behaviours ☐ Yes ☐ No If yes, please describe:

Suicide Risk (Please check all that apply) ☐ Current Risk, ☐ Past Risk, ☐ Previous Suicide Attempts
Additional details (if applicable):

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

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

| 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**

**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.**

**CLIENT SIGNATURE:** **DATE:**

**DD/MMM/YYYY**

| INTERNAL USE ONLY | | | | |
|---|---|---|---|---|
| DATE RECEIVED | | WAITLISTED | ☐ YES | ☐ 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 1-604-988-2618 |
| TP Squamish | Phone: 604-390-0395 | Fax 1-604-390-1474 |