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:**

TurningPoint

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

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)

TurningPoint

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

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):

TurningPoint

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

TurningPoint

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				

Please complete the *Care Facility Admission Consent Form* on the next page. If you are receiving financial assistance from the Ministry of Social Development and Poverty Reduction, please also complete the *Confirmation of Income Form* on the last page. Once completed, please send the full intake package to intake@turningpointrecovery.com.

BRITISH COLUMBIA | Ministry of Health

CARE FACILITY ADMISSION CONSENT

HLTH 3909 2019/09/23

This form is to be completed by the manager giving due consideration to Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFAA) and the Practice Guidelines for Seeking Consent to Care Facility Admission (Ministry of Health). Information is being collected under the authority of the HCCCFAA. A **manager** is defined by the HCCCFAA as an individual who is responsible for either or both of: (a) the operation of a care facility, or (b) admissions to a care facility.

INFORMATION OF ADULT TO BE ADMITTED

Last Name of Adult to be Admitted	First Name of Adult to be Admitted	Second Name(s)
Personal Health Number (PHN)	Birthdate (YYYY / MM / DD)	

Consent provided by (choose one)

☐ the adult to be admitted ☐ the substitute (adult determined to be incapable through assessment)

PROPOSED ADMISSION

It is proposed that the adult be admitted to the following facility:

Name of Care Facility	Address of Care Facility

CONSENT OF ADULT OR SUBSTITUTE DECISION MAKER

Adult or substitute providing consent to mark the appropriate boxes:

☐ I have been given information about this care facility, including the care that will be received, the services that will be available and the circumstances in which I (or the adult) may leave the care facility.

☐ I have been given the opportunity to ask questions about admission to this facility, its benefits and risks, and the options if admission is not accepted.

I understand:

☐ The care options available and possible outcomes.

☐ I have the right to give or refuse consent to admission to this care facility.

☐ I can revoke consent to admission to this care facility at any time.

☐ If care and accommodation is offered at this care facility and I accept, it will become my (or the adult's) home.

Additional Comments:

Consent to the above-named care facility was:

☐ provided in writing ☐ provided orally ☐ inferred from conduct - describe:

ADULT TO BE ADMITTED - WRITTEN CONSENT

☐ **I CONSENT to being admitted to the above-named care facility.**	Signature of Adult to be Admitted	Print Name of Adult to be Admitted
		Date Signed (YYYY / MM / DD)

OR: SUBSTITUTE DECISION MAKER - WRITTEN CONSENT

☐ **On behalf of the above-name adult, I CONSENT to the adult being admitted to the above-named care facility.**	Signature of Substitute Decision Maker	Relationship to Adult
	Print Substitute's Full Name	Date Signed (YYYY / MM / DD)

OR: MANAGER - CONSENT PROVIDED ORALLY OR INFERRED FROM CONDUCT

☐ **The above-named adult (or substitute decision maker on behalf of the adult) has CONSENTED to being admitted to the above-named care facility.**	Signature of Manager	Date Signed (YYYY / MM / DD)
	Print Name of Manager	Organization/Health Authority
	Name of Substitute Decision Maker	Relationship to Adult

Save Print Clear Form

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

CONFIRMATION OF INCOME

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The information will be used for eligibility purposes. The collection, use and disclosure of personal information are subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Questions regarding the collection, use, and disclosure of personal information can be directed to an Employment and Assistance Worker by phone at 1-866-866-0800.

Service Provider Name	Fax Number
TURNING POINT RECOVERY SOCIETY - SITE:	
Address	

Clients receiving assistance from the Ministry of Social Development and Poverty Reduction must inform the Ministry of their request to enter residential care/treatment prior to funding. The Ministry will process applications for funding once notified of the client's arrival on the date of admittance by the facility faxing the HR3319 to the Ministry of Social Development and Poverty Reduction.

Client Full Name		
Phone Number	Date of Birth	SIN Number

I hereby authorize the staff from the Ministry of Social Development and Poverty Reduction to release information from my file required to establish eligibility for funding. This includes any income received or pending, and any missing documents that might affect my eligibility.

Client Signature _____ Date Signed _____

To be completed by ministry staff

Does the client have an open file? ◯ Yes ◯ No

Is the client receiving any other income? ◯ Yes ◯ No

Source of income _____

Amount of income _____

Is the client pending any other income? ◯ Yes ◯ No

Source of pending income _____

Notes

Ministry Staff Signature _____ Date Signed _____

*Be advised information is accurate as declared to the Ministry as of the date signed.