AMETHYST HOUSE REFERRAL PACKAGE

Referring Agent Check List

Ensuring that your client is fully informed will contribute to her having as successful stay at Amethyst as possible. Please review the following with your client prior to their arrival:

- ☐ Referral package.
- ☐ Review and signing of Amethyst House Guidelines.
- ☐ What you need to know.
- ☐ Reasons for discharge from Amethyst House.
- ☐ Medications- insuring client is medically stable and all medications that come to Amethyst House are blister-packed.
- ☐ Funding verification on referral package
- ☐ Reviewing that Amethyst House is a Supportive Recovery program and not a treatment program.
- ☐ Program duration desired:

  □ 30 day □ 60 day □ 90 day

Please note:
If you are wanting an extension to your 30-day program the request must be submitted within the first 15 days of your stay at Amethyst House. *To receive the full benefits of the program, it is recommended to complete the 90-day.*

Referral form MUST be completed in full.
If a question is not applicable, please enter N/A.

Comox Valley Transitions Society

CONFIDENTIAL REFERRAL FORM

AMETHYST HOUSE
280 2nd Street
Courtenay, BC
V9N 1B6
Ph: 250-871-2570 Fax: 250-871-2573
email: *ahadmin@cvts.ca*

CLIENT NAME: ____________________

DATE OF REFERRAL: ____________________
DD/MM/YYYY

Referring Agent: ____________________ **Title/Position:** ____________________
Phone #: ____________________ **Fax #:** ____________________
Email: ____________________

Is this referral source from any of the following? Supervised Consumption Site ☐ Overdose Prevention Site ☐ None of the above ☐

PART 1 – PERSONAL INFORMATION

Preferred Names: ____________________

Address: ____________________ **Postal Code:** ____________________

If unhoused, where do you stay currently: Couch Surfing ☐ Staying with Family ☐ Staying with Friends ☐ Shelter ☐ Street ☐ Incarcerated ☐

Phone #: 1) ____________________ 2) ____________________ **Messages:** YES ☐ NO ☐
Email: ____________________ **Messages:** YES ☐ NO ☐

Date of Birth: ____________________ (MM/DD/YYYY) **SIN #:** ____________________
PHN #: ____________________

Marital Status: Single ☐ Common-Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Self-identified Gender: (select all that apply) F ☐ Transgender ☐ Non-Binary ☐ Two-Spirit ☐ Questioning ☐ My Gender is: ____________________
Preferred Pronoun: She/Her ☐ He/Him ☐ They/Them ☐ My Pronouns are: ____________________

Cultural / Ethnic Identity: ____________________ **Status:** YES ☐ NO ☐

Next of Kin: ____________________ ____________________ ____________________
Name Relationship Telephone

Emergency Contact: ____________________ ____________________ ____________________
Name Relationship Telephone

Amethyst House

PART 2 – Income and Funding Sources

Have funding options been explored? YES☐ NO ☐ **Note: Funding resources must be in place prior to attending**

Employment Status: Full Time ☐ Part Time ☐ Unemployed ☐

If employed, what industry are you employed in? ____

Income Source: Employment ☐ E.I. ☐ Pension ☐ Income Assistance ☐ Basic ☐ PPMB ☐ PWD ☐

Other ☐ ______________________________

Does the applicant have funding for travel to and from treatment? YES ☐ NO ☐

Have travel arrangements been arranged? YES ☐ NO ☐

Does applicant have access to the following? Birth Certificate ☐ BC Identification ☐ SIN # ☐ Bank Acct ☐

PART 3 – Education

What is your highest level of education? Grade School (K-7) ☐ Some High School ☐ High School or GED ☐ Trade School ☐ Some College/University ☐ College/University Degree ☐ None ☐

What level of literacy is the applicant at? Low ☐ Medium ☐ High ☐

Does applicant require any reading supports? YES ☐ NO ☐
Does applicant require any writing supports? YES ☐ NO ☐

If yes to either or both of the above, please explain what additional supports would be required to support the applicant: ____
____

PART 4 – Family and Living Arrangements

Total Number of Dependent Children: ___ **Have children been living with their parent(s):** YES ☐ NO ☐

Does applicant currently have an open file with MCFD? YES ☐ NO ☐

Is there currently a supervision order from a family protection agency? YES ☐ NO ☐

Does the applicant have any outstanding child custody issues? YES ☐ NO ☐

Does the applicant have a no-contact order with their partner? YES ☐ NO ☐

What is the applicant's current living arrangements? With my family ☐ With extended family ☐

With parent(s) ☐ With friend(s) ☐ As part of a couple ☐ a single parent ☐ With partner and kid(s) ☐

Alone ☐ Recovery Home ☐ Homeless ☐ Shelter ☐ Other (specify) ☐ ___________________________

PART 5 – Legal

Has applicant been mandated to attend treatment? YES ☐ NO ☐ **if yes, by whom?** ____________________

Safety concerns/history or current violence in relationships/client has been violent with others? ________
____
____

Protection Orders/No Contact Orders: YES ☐ NO ☐ Required ☐

Victim Services involvement: YES ☐ NO ☐ Required ☐ PBVS ☐ CBVS ☐ SAS ☐

Does the applicant have any current or prior involvement in the legal system? YES ☐ NO ☐
If yes, please describe: ____

If yes, were charges (select all that apply): Violent ☐ Sexual ☐ Drug-related ☐ Sexual ☐ Involved a minor ☐ Involved a partner ☐

List of upcoming or pending court dates: ____

Is the applicant currently: On Parole ☐ Serving a Probation Order ☐ Bound by Release Order/Undertaking ☐

If yes to either of the above, please provide the following information and include the Parole/Probation/Bail Officer in *Part 13: Consent for Release of Treatment Information*

Parole/Probation/Bail Officer Name: ________________________________ **Phone Number:** ____________________

PART 6 – Previous Treatment Centres

Has applicant recently started or completed a withdrawal management program? YES ☐ NO ☐

If yes, when: _____________________

Has applicant recently started or completed a bed-based treatment program YES ☐ NO ☐

If yes, what dates: _____________________

Has applicant EVER been in a bed-based treatment for their substance use before? YES ☐ NO ☐

If yes, what dates: _____________________

PART 7 – Post Treatment Plan

Are there supportive services available upon discharge from referring agent? YES ☐ NO ☐

Where does the applicant go in their community for supports? ______________________________________

____

____

Has the applicant completed pre-treatment and/or healing sessions (e.g. AA, NA, Counselling, etc.)?
YES ☐ NO ☐

If yes, please explain what type of support and how many sessions have been completed: ______________

____

Does applicant require assistance with housing applications? YES ☐ NO ☐

PART 8 – Current Situation/Area of Concern

Current Situation / Areas of Concern (including crisis or circumstances leading to Supported Recovery) ____

____

____

____

____

What current indicators lead you to assess this applicant as being eligible and emotionally ready for stabilization/supported recovery programming within a communal-living environment? ______

____

____

____

Does applicant have any needs to things that they feel will enhance their treatment experience?
(e.g. culture, art therapy, etc.) ____

____

____

PART 9 – Medical Information

Does the applicant have any chronic or acute medical issues that could affect their participation in the program? YES ☐ NO ☐ if yes, please describe: ____
____

Does the applicant have any disabilities that the recovery center should be aware of (e.g visual impartments, hearing aids, mobility, etc.?) YES ☐ NO ☐
If yes, please describe what ability support the applicant would require**:** ______________________________
____
____

Medications Currently Taking (prescription/over the counter/supplements):

Medication Name	Current Dosage	Condition Treated	Taken for How Long?

Medical Diagnosis/Major Illness
____
____
____
____
____

Other Current Physical/Health Concerns
____
____
____

Communicable Diseases: TB ☐ HIV ☐ Hep A B or C ☐ Other ☐ ________________________

Date Last Tested: ____________________________________

Pregnancy: Yes ☐ No ☐ Weeks: ____________ Due Date: _____________________

Family Physician: Yes ☐ No ☐ Name: ____

OAT Therapy (MMT):

Never ☐

Past ☐

When: ________________________

How Long on MMT: _____________

Dose: _________________________

Current ☐

How long on OAT: ____________________

Current Dose: _________________________

Maintenance ☐ Reduction ☐

Carry Privileges: Yes ☐ No ☐

Prescribing Physician: ____________________________________ Tel: ___________________________

Allergies (drug, food, environmental – include reactions and remedies, i.e. inhaler, antihistamine):

____

____

____

Special Needs/Challenges: ____

____

Special Aid(s) Used/Required: ____

____

Special Dietary Needs: ____

____

____

Additional Information about Health Concerns: ____

____

____

____

____

PART 10 – Mental Health Wellness

What is the applicant's sobriety date? ___________________________________

Mental Health History/Symptoms (include psychiatric diagnoses, hospitalizations, other treatment):

____

____

____

____

____

Has the applicant been impacted by systemic, trauma-related histories and/or experiences (e.g. Indian Residential School, Day School, extended hospitalization, 60s Scoop, foster care, intergenerational survivor etc.

YES ☐ NO ☐ *if yes, and you feel safe to do so, please provide further information:* _________________

____

____

Does the applicant have a history of or have they ever been diagnosed with a mental health condition, disability or challenge by a medical professional? (check all that apply)

Chronic Pain Disorder ☐ Mood Disorder (depression or bipolar disorder ☐ Brain/Head Injury ☐

Anxiety or Panic Disorder ☐ Eating Disorder ☐ PTSD ☐ Personality disorder ☐

Emotional Trauma or occupational Stress Injury ☐ Psychotic Episode or disorder ☐ Schizophrenia ☐

Does the applicant have a history of: Suicidal Ideation ☐ Self-Harm ☐ Previous Attempts ☐

Please provide details: ____

____

____

Additional Information on Mental Health Concerns: ____

____

____

____

____

____

PART 11 – Spiritual

Please share any spiritual or cultural involvement that the applicant takes part in or would like to explore in their healing journey: ____

____

____

PART 12 – Substance Use/Misuse History

In the past year what substances have you used/misused and what is the date of your last use for each substance? *Please circle primary drug(s) of choice*

Substance	Est. Age of First Use	**How Often** (Rarely, occasionally, monthly, weekly, daily)	Amount/Quantity Used	Date of Last Use

Other addictions: (sex, food, gambling, etc.)____

____

____

____

PART 13 – Release of Information (ROI)

Client Authorization: My signature below verifies that the information I have provided to the Referring Agent noted below is for the purposes of this referral and my application for residence within Amethyst House's Program(s) is accurate to the best of my knowledge. My signature also authorizes the release and/or exchange of information between Amethyst House staff and all the service providers noted below. This authorization is valid for pre-admission collaboration of care purposes (including a discharge summary) and for the entire duration of my residence within Amethyst House.

____ ________________________
Client Signature Date: DD/MM/YYYY

Referring Agent Identification/Verification:

____ ________________________
Print Name Date: DD/MM/YYYY

____ ________________________
Signature Agency/Organization

SERVICE PROVIDER	NAME	AGENCY	PHONE AND/OR EMAIL
Physician (GP)			
Addictions Counsellor			
Addictions Physician			
Psychiatrist			
Mental Health Worker			
Other Counsellor			
Probation/Parole Officer			
Income Assistance			
MCFD Worker			
Lawyer			
Other			
Other			
Other			

PART 14 – Early Exit Transition Plan

It is understood that if I leave Amethyst House Program, am discharged early or if I do not arrive for my scheduled intake at Amethyst House, my referral liaison and/or my early/emergency contact will be notified. I must also have a plan in place for shelter and transport prior to admission.

Client Name:	**Date of Birth:** DD/MM/YYY
Early Exit Plan:	
Transportation plan and cost:	

Community Contact for Early Exit Support:

My emergency contact will also be contacted if I need to stay overnight at the hospital.

Name of Contact for Early Exit Plan: ____	**Telephone:** ______________________________ **Email:** ________________________________
Name of Emergency Contact: ____	**Telephone:** ______________________________ **Email:** ________________________________

I agree that I am responsible for all transportation costs and that I am responsible for knowing the fees associated with bus, cab and/or ferry. I must have these funds available to me upon intake.

Client Signature: ______________________________ Date: DD/MM/YYYY __________________

Worker Signature: ______________________________ Date: DD/MM/YYYY __________________

PART 15 – MSDPR FUNDING VERIFICATION – *Must be signed by the client*

To: Ministry of Social Development & Poverty Reduction

Date: ________________

Fax #: ________________

From: ____

Fax #: ____________________

Client Name: __________________________________

DOB: _____/____/_______
DD / MM / YYYY

SIN: ______________________

This person has been referred for admission to Amethyst House Residential Stabilization and Supportive Recovery Services. Prior to admission we require confirmation that the client's per diem costs (less any non-exempt income) will be paid by MSDPR while in receipt of and eligible for income assistance. Once the client has been admitted we will send an admission report.

Income from Other Source(s): $________________ Source: _________________________________

Client Authorization: I, ____ authorize the Ministry of Social Development & Poverty Reduction to confirm eligibility for funding and to release any related information to Amethyst House staff.

Client Signature: ____________________________________ Date: __________________________

MINISTRY OF SOCIAL DEVELOPMENT & POVERTY REDUCTION - VERIFICATION

☐ Client has an open and active file

☐ Client eligibility to be determined

☐ Client file has been closed

☐ Client is eligible for funding as follows:

Comments:

Client's monthly per diem will be paid by MSDPR as per current eligibility less and non-exempt income from other sources as follows:

Clients contribution (non exempt income)

$______________________

Non exempt income from: ____

Maximum Amount Payable by MSDPR per Month

$______________________

MSDPR Contact Name: __________________________

Tel/Fax: ____________________________________

Email: _____________________________________

Date: ______________

Place Office Stamp Here