641 Menzies Avenue
Courtenay, BC V9N 3C3
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cvrccourtenay@gmail.com

Comox Valley Recovery Centre Referral

Referral Date: _____ Referring Agent: _____

Agent Phone #: _____ Fax #_____ Email _____

Client Name:_____ Other/Preferred Name:_____

Date of Birth: _____ Personal Health Number: _____

First Nations? Y/N Status # _____ Band _____

Address: _____ City:_____ Postal Code:_____

Does client rental accommodation outside of the facility residence need to be maintained? Y/N

Client Phone#: _____ Messages: Y/N
Client Email: _____

Next of Kin: _____ _____ _____
Name Relationship Telephone #

Emergency Contact: _____ _____ _____
Name Relationship Telephone #

Income Source: □ Employment □ Income Assistance □ EI □ Pension □ PWD □ Band □ CERB

Suicide Risks: □ Current □ Ideation □Previous Attempts:_____

Restraining Order/No Contact Order: □ Y □ N

Assault against a Police Officer/Sexual Offences: □ Y □ N

On Probation/Bail: □ Y □ N If yes attach conditions: _____

Legal Concerns or pending Court dates that may interfere with treatment: □ Y □ N _____

Mental Health Concerns: □Y □ N If yes, details of diagnosis/treatment/previous treatment: _____

_____

_____

Physical Health: If yes, please include details
Mobility Issues □ Y□ N Open Wounds □ Y□ N Diabetes □Y□ N Allergies □Y□ N
Broken Bones □ Y□ N Outstanding follow up appointments □Y□ N Special Dietary Needs □Y□ N

_____

_____

TB: Y□ N□ HIV: Y□ N□ Hep A B or C: Y□ N□ MRSA: Y□ N□

Family Physician: _____

Medications currently taking – including prescriptions/over the counter/supplements

Name of Med	Current Dosage	Condition Treatment	Taken for how long

** Medication coverage is the sole responsibility of the person. This needs to be organized prior to admission.

CVRC will not cover any medication costs. All medications need to be arranged and prescription sent to: **Comox Valley Pharmacy** by fax to be blister packed before admission. **Fax: *250-941-6686***
Phone: *250-941-6685* **

OAT Medication: please circle one: **Methadone Suboxone Kadian**

Current Dose: _____How Long:_____Prescribing Physician: _____
Clinic Name: _____ Clinic Phone # _____

** Original prescribing physician must continue to maintain client OAT prescription for duration of program at CVRC

Substance Use/Misuse History:

Substance	Method	Years of Use	Frequency	Date of Last Use

Other Addictions (Sex, Food, Gambling, ect) _____

Detox Plan (clients attending CVRC are required to be detoxed before entry): _____
_____

Payment Information:

- **Self-Pay:** Prior to the client's entry to the facility, payment of $155 per day is required.
- **Income Assistance:** As income aid does not fully pay per diems, a backup source must also be used. For more information about secondary sources, kindly contact CVRC.
- **Schedule H:** Only referrals to the MHSU
- **FNHA:** Before to admission, an application must be made.
- **Band funding:** Before being admitted, a letter of approval must be submitted.
- **Insurance:** Before admission, a letter of approval must be given.

Length of program □ 30 Day □ 60 Day □ 90 Day
If wanting to apply for an extension to your 30 day program the request must be submitted by DAY 14

What makes CVRC program right for you? _____
_____
_____

What Changes are you prepared to make while in the program: _____
_____
_____

Early Exit Transition Plan:
If I am asked to **leave the program early**, choose to **self-withdraw**, or f**ail to appear for scheduled intake** at CVRC, my referral agent, emergency contact, probation officer, and others will be notified. Prior to admission, I must also have a plan in place for shelter and transportation back to my community.

If I need to stay overnight at the hospital, my emergency contact will also be contacted.

Name of Contact: _____ Relationship:_____ Telephone # _____
Name of Contact: _____ Relationship:_____ Telephone # _____

Early Exit Transportation (family, bus, personal vehicle):_____
Plan to Stay safe, including shelter should transportation not be available until the following day: _____
_____
_____

Individual has own Naloxone Kit Y□ N□ Naloxone Kit to be provided by CVRC upon Discharge Y□ N□

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

_____ _____
Name Signature

Client Authorization:
My signature below verifies that the information I have provided either by Self or with a Referring Agent noted below for the purposes of this referral and my application for residence within CVRC's program is accurate and to the best of my knowledge. My signature also authorizes the release and/or exchange of information between CVRC staff and all service providers noted below. The authorization is valid for pre, during and past treatment residency with CVRC

Provider	**Name**	**Agency**	**Phone #**
Physician			
Clinician			
Probation			
Lawyer			
Family Member			
Other			

_____ _____
Client Signature Date

_____ _____
Referring Agent Signature Date

I have received, reviewed, and understand the Comox Valley Recovery Centres rules and guidelines

_____ _____ _____
Name Signature Date