641 Menzies Avenue
Courtenay, BC V9N 3C3
Ph: 250-338-7144
Fax: 250-338-6242
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:_____
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: Courtenay Rexall by fax to be blister packed before admission. **Fax: 250-338-9470** Phone: 250-334-2481 **

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**: The cost of $150/day must be in place prior to client admitting to the facility.
□ **Income Assistance**: Income assistance alone does not cover full per diems and a secondary source will need to accompany. Please contact CVRC for further information regarding secondary sources
□ **Schedule H:** MHSU referrals only
□ **FNHA:** Approval must be submitted to prior to admission
□ **Band Funding:** approval letter must be submitted prior to admission
□ **Insurance:** approval letter must be submitted prior to admission

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:
In the event I am asked to leave the program early, chose to self withdrawal, or do not arrive for scheduled intake at CVRC; my referral agent, emergency contact, probation officer ect. will be notified. I must also have a plan in place for shelter and transport back to my community prior to admission.
My emergency contact will also be contacted if I need to stay overnight at the hospital.

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