

641 Menzies Avenue Courtenay, BC V9N 3C3 Ph: 250-338-7144 Fax: 250-338-6242

cvrccourtenay@gmail.com

Referral Package for Comox Valley Recovery Centre

Referring Agency:	Referr	al Date:	
Referring Agent Information:			
Name:	<u></u>		
Phone Number:			
Fax Number:	<u></u>		
Email:	<u></u>		
Part 1 - Demographic Information			
Full Name:			
Other/Preferred Names:			
Date of Birth:	(yyyy/mm/dd)		
Personal Health Number:			
First Nations:	Status: Y□ N□		
Band:			
Sex:			
Gender:			
Cultural/Ethnic Identity:		_	
Current Address:		_	
City/Prov:		_Postal Code:	
Phone Number:	Messages: Y□	$N\Box$	
Email:			
Next of Kin:	D.1.('1'		T.1.1. N. 1
Name	Relationship		Telephone Number:
Emergency Contact:			
Name	Relationship		Telephone Number:
Does client have any rental accommodati provide the address:		eeds to be main	tained financially? If yes, please

Part 2 - Readiness	
counselling, and educational group	a structured program of recovery. You will be expected to attend peer support meetings, os. Your use of electronic devices will be limited. You are obligated to participate uidelines. Do you think that CVRC is right for you?
Are you prepared to follow sugges $Y \square N \square$	stions and make significant changes in thinking, lifestyle, and behaviour?
Part 3 - Family	
Dependent Children: Y□ N□ Hov	w many? MCFD Involvement
* ·	Part Time□ Unemployed □ t□ EI□ Pension□ stance□ PWD□ Band□
Part 4 - Risk Screens	
Self Harm/Suicide Risk:	
Does client have a current history	of self harm other than substance abuse? If yes, please provide information below:
Has client engaged in any previou attempted:	s suicide attempts. If yes, please provide information below including the method
Does client currently have suicidal	thoughts? Y \(\text{N} \(\text{D} \)
Does client have a current plan for	suicide? Y \subseteq N \subseteq
Physical Risks:	
Is the client at risk of a fall that co If yes, please explain:	uld injure them? Y□ N□

 $Y \square N \square$

Attach Behavioural Care Plan if Applicable.

Does the client pose any threat due to violent behaviour?

Part 5 - Legal
Restraining Order/No Contact Orders: $Y \square N \square$
Assault against a Police Officer: Y□N□
Sexual Offences: $Y \square N \square$
On Probation/Bail: Y□ N□ If yes attach conditions: Probation Officer name and contact information must appear on page 8 of this application.
Legal Concerns or pending Court dates that may interfere with treatment: $Y \square N \square$
List convictions below or attached a C.S.O report to this application:
Part 6 – Medical Information
Mental Health Diagnosis (known formal diagnosis):
Client's Mental Health Concerns:
Physical Health: Mobility Issues: Y□ N□ If Yes explain:
Open Wounds: Y□ N□ If Yes explain:
Diabetes: Y□ N□ If Yes explain:
Allergies: Y□ N□ If Yes explain:
Other: Y□ N□ If Yes explain:
Communicable Diseases:
TB□ HIV□ Hep A B or C□ MRSA□ Other□ Explain:
Date last tested for HIV, HEP A B or C:
Family Physician: Y N N Name:

Part 7 - Medication

Prescribing Physician: Physician contact information: Dedication coverage is the sole responsibility of the person. This needs to be organized prior to admission. Civil not cover any medication costs. All medications need to be arranged and prescription sent to Comox Va Pharmacy (fax number: 250-941-6686) to be blister packed sthe client prescribed Opioid Agonist Therapy? If so, please circle one: Methadone, Suboxone, or Kadian Maintenance Therapy: Current Dose:	Prescribing Physician: Physician contact information: Predication coverage is the sole responsibility of the person. This needs to be organized prior to admission. Oxidi not cover any medication costs. All medications need to be arranged and prescription sent to Comox Val Pharmacy (fax number: 250-941-6686) to be blister packed s the client prescribed Opioid Agonist Therapy? If so, please circle one: Methadone, Suboxone, or Kadian daintenance Therapy: During the company of the company of the client admittenance Therapy:	Name	Current Dosage	Conc	lition Treated	Taken for how long	
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Part 11 - 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 before, during, and up to 100 days post residency with CVRC.

Service Provider	Name	Agency	Phone	
Physician				
Clinician				
Counsellor				
Psychiatrist				
Probation/Parole Officer				
Lawyer				
Other				
Family Member				
Family Member				

Part 10 - Early Exit Transition Plan

In the event I am asked to leave the program early, or I do not arrive for scheduled intake at CVRC; my referral agent, emergency contact, probation officer etc. will be notified. I must also have a plan in place for shelter and transport back to my community prior to admission.

Client Name:	_ Date of Birth:			
Early Exit Plan:				
Name of Contact:	Phone Number:			
Early Exit Transportation (family, bus, personal vehicle):				
Plan to stay safe:				
Individual has own Naloxone Kit: $Y \square N \square$ Naloxone Kit to be Provided by CVRC upon Discharge: $Y \square N \square$				
My emergency contact will also be contacted if I need to stay overnight at the hospital				

I agree that I am responsible for all transportation costs and 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:
Referral Signature:	Date: