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# Application Package for Comox Valley Recovery Centre

Referring Agency: _____ Referral Date:_____

Referring Agent Information:

Name:_____

Phone Number:_____

Fax Number:_____

Email:_____

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**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□

Email: _____

Next of Kin: _____

Name Relationship Telephone Number:

Emergency Contact: _____ _____

Name Relationship Telephone Number:

Does client have any rental accommodation outside of the facility that needs to be maintained financially? If yes, please provide the address:_____

**Part 2 - Readiness**

Comox Valley Recovery Centre is a structured program of recovery. You will be expected to attend peer support meetings, counselling, and educational groups. Your use of electronic devices will be limited. You are obligated to participate actively and follow all rules and guidelines. Do you think that CVRC is right for you?
Y□ N□

Are you prepared to follow suggestions and make significant changes in thinking, lifestyle, and behaviour?
Y□ N□

**Part 3 - Family**

Dependent Children: Y□ N□ How many? _____ MCFD Involvement □

Employment Status: Full Time□ Part Time□ Unemployed □
Income Source: Employment□ EI□ Pension□
Income Assistance□ 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 previous suicide attempts. If yes, please provide information below including the method attempted:
_____
_____
_____

Does client currently have suicidal thoughts? Y□ N□

Does client have a current plan for suicide? Y□ N□

**Physical Risks:**

Is the client at risk of a fall that could injure them? Y□ N□
If yes, please explain: _____
_____
Does the client pose any threat due to violent behaviour? Y□ N□

Attach Behavioural Care Plan if Applicable.

**Part 5 - Legal**

Restraining Order/No Contact Orders: Y□ N□

Assault against a Police Officer: Y□N□

Sexual Offences: Y□N□

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□ N□

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□ Name: _____

**Part 7 - Medication**

Medications Currently Taking- including prescriptions/over the counter/supplements

| Name | Current Dosage | Condition Treated | Taken for how long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Prescribing Physician:_____

Physician contact information:_____

**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 (fax number: 250-941-6686) to be blister packed**

**Is the client prescribed Opioid Agonist Therapy?** If so, please circle one: **Methadone**, **Suboxone**, or **Kadian** Maintenance Therapy:

Current Dose: _____How long: _____

Prescribing Physician: _____Clinic Name: _____ Phone Number: _____

**Part 8- Substance Use/Misuse History**

| Substance | Method | Years of Use | Frequency | Date of Last Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Other Addictions (Sex, Food, Gambling etc): _____

**Part 9 - Payment Information**

□ **Income Assistance-** Confirmation Required
□ **Schedule H-** MHSU Clients Only
□ **Self Pay –** The cost of $155.00 per day must in place prior to the client admitting to the facility
Program costs are due upon admission.
□ **FNHA –** approval must be submitted to CVRC before admission
□ **Band –** approval in the letter from must be submitted to CVRC before admission
□ **Company-** Invoice who? Please complete the following:
**Contact Name:** _____
**Company Name/Agency:** _____
**Phone:** _____ **Fax:** _____
**Mailing Address:** _____

**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□ N□
Naloxone Kit to be Provided by CVRC upon Discharge: Y□ N□

**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:_____