Eastern Health

Adult Addictions Inpatient Treatment
REFERRAL APPLICATION
(Part I)

Western Health

Name

HCN

Date of Birth

Please indicate if the below has been completed and attached:

- ❑ Assessment
- ❑ Medical Assessment
- ❑ Client Expectations Agreement
- ❑ Health Care Number

It is vital that ***ALL*** of the above information be received PRIOR to the assignment of an admission date. This will allow the individual access to an earlier admission date should there be a cancellation.

May a staff person telephone the client one week before his/her admission date to confirm his/her attendance, answer any questions they may have, and provide them with additional information about the program?

❑ Yes ❑ No

If not at home, may we leave a message? ❑ Yes ❑ No

If an alternate person will be coordinating this referral after the assessment has been completed and forwarded, please provide the name and telephone number of that person:

_____

_____

_____

_____

_____

_____

Name:_____ Date:___DD/MONTH/YYYY_____

Signature:_____

Eastern Health

Adult Addictions Inpatient Treatment
REFERRAL APPLICATION
(Part II)

Western Health

Name

HCN

Date of Birth

(To be completed by referring healthcare provider)

Name		Next of Kin	
Mailing Address		Relationship	
		Telephone Number	
Telephone Number		Email Address	
Alternate Number			
Email Address		Referral Source	
Date of Birth	DD/MONTH/YYYY	Agency	
Health Care Number		Telephone Number	
Gender		Email Address	
Language of Preference		Mailing Address:	
Are you of Aboriginal Origin?			

Does the client have an address to return to? ❑ Yes ❑ No
If different than above please provide:

_____

Will you the referral source be providing follow up care? ❑ Yes ❑ No
If no, please provide contact information for the health care provider providing follow up care (name, address, telephone number, fax number and email address)

_____

_____

_____

_____

1. Is this a referral for:

Substance Abuse Treatment ❑ Yes ❑ No
Problem Gambling Treatment ❑ Yes ❑ No
Both Substance Abuse and Problem Gambling Treatment ❑ Yes ❑ No

2. Reason for referral or admission to your program (presenting problems/concerns):

_____

_____

_____

3. Previous Addictions Treatment:

_____

_____

_____

Name:_____ Date:DD/MONTH/YYYY

Signature:_____

Eastern Health

Adult Addictions Inpatient Treatment REFERRAL APPLICATION (Part III)

CL1970 1390 09 2015

Western Health

Name

HCN

Date of Birth

4. Substance Abuse /Gambling History:

Substances of Choice	Method of use: oral/smoked/snorted/IV	Length of use	Amount consumed daily	Date of last use

Type of Gambling	Duration of problem gambling	Frequency	Last date of gambling	SOGS score

Does the client smoke? ❑ Yes ❑ No If yes: Frequency _____

Is the client willing to participate in a smoking cessation program? ❑ Yes ❑ No

5. History of Withdrawal Symptoms:

Has the client ever experienced severe symptoms such as seizures or hallucinations when he/she has stopped drinking or using in the past? ❑ Yes ❑ No If yes, please describe:_____

_____

_____

_____

_____

Is the client requiring withdrawal management support? ❑ Yes ❑ No

Are there withdrawal management services available to the client in his/her own community? ❑ Yes ❑ No

Is the client currently using benzodiazepines or barbiturates? ❑ Yes ❑ No

Is the client capable of his/her own self-care? ❑ Yes ❑ No

Does the client have diabetes? ❑ Yes ❑ No

Does the client have high blood pressure? ❑ Yes ❑ No

Does the client have heart problems? ❑ Yes ❑ No

Is there evidence of head injury? ❑ Yes ❑ No

Has the client ever experienced seizures? ❑ Yes ❑ No

Name:_____ Date:DD/MONTH/YYYY

Signature:_____

Eastern Health

Adult Addictions Inpatient Treatment REFERRAL APPLICATION (Part IV)

CL1970 1390 09 2015

Western Health

Name

HCN

Date of Birth

6. Psychological/Mental Health:

Has the client ever been diagnosed with a mental health problem by a qualified mental health professional? ❑ Yes ❑ No

If yes, what was/is the diagnosis?_____

Has the client ever been hospitalized for a mental illness or a mental health problem? ❑ Yes ❑ No

If yes, when? _____

Reason(s):

Suicidal ideation	❑ Yes	❑ No	❑ Past ❑ Current		
Suicide attempts	❑ Yes	❑ No	Date of last attempt? DD/MONTH/YYYY		
Self -harm (mutilation)	❑ Yes	❑ No	Hallucinations (auditory / visual)	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Obsessive/compulsive behavior	❑ Yes	❑ No
Mania	❑ Yes	❑ No	Panic attacks	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Nightmares/flashbacks	❑ Yes	❑ No
Phobias	❑ Yes	❑ No	Homicidal Ideation	❑ Yes	❑ No
Eating disorders	❑ Yes	❑ No	Fire Setting	❑ Yes	❑ No

Comments: _____

7. Marriage/Relationship (status, impact of substance use or gambling, partner's substance use or gambling behavior):

8. Family (family of origin, impact of alcohol/drug use or gambling on family members, history of substance use or gambling in family):

9. Social/Leisure (peer group, social life, impact of substance use or gambling):

Name:_____ Date:DD/MONTH/YYYY

Signature:_____

Eastern Health

Adult Addictions Inpatient Treatment REFERRAL APPLICATION (Part V)

CL1970 1390 09 2015

Western Health

Name

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Date of Birth

10. Education level:

- ☐ College (completed)
- ☐ University/College (partial)
- ☐ Technical/Trade School
- ☐ University (MA)
- ☐ Secondary (completed)
- ☐ Elementary (grade 8 or less)
- ☐ University (MA, PHD)
- ☐ Secondary (partial)
- ☐ Unknown

11. Employment:

- ☐ Full-time
- ☐ Retired
- ☐ Student/Retraining
- ☐ Disability Insurance
- ☐ Family Support/ Inheritance
- ☐ Part-time
- ☐ Disability assistance
- ☐ Unemployed seeking work
- ☐ Guaranteed Income (pension)
- ☐ Social Assistance
- ☐ Employment Insurance
- ☐ Homemaker
- ☐ Unemployed not seeking work
- ☐ Unknown Financial Status
- ☐ Other (investment/student loan)

If the client is not working, when was he/she last employed?_____

Impact of substance use/gambling on education/employment:

_____

_____

_____

12. Legal History:

Past Criminal Charges: ❑ Yes ❑ No If yes, specify:_____

History of Assault/Violence: ❑ Yes ❑ No If yes, specify:_____

Current Legal Involvement: ❑ Yes ❑ No If yes, specify:_____

(Charges, probation order, upcoming court) ***(See criteria for admission)***

Are you coming for treatment because of a court order? ❑ Yes ❑ No

13. Group Therapy.

Is the client willing to participate in group therapy and a group environment? ❑ Yes ❑ No

Comments:_____

_____

_____

_____

_____

_____

14. Specific Needs (learning disability, difficulty with reading and/or writing, hearing impairment, physical disability, intellectual or developmental disability, cognitive or memory problems, speech impairment, language barriers):

_____

_____

_____

Name:_____ Date:DD/MONTH/YYYY

Signature:_____

Eastern Health

Adult Addictions Inpatient Treatment REFERRAL APPLICATION (Part VI)

CL1970 1390 09 2015

Western Health

Name

HCN

Date of Birth

15. Clinician's Impressions: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____	_____	DD/MONTH/YYYY
Printed Name of Client	Signature of Client	Date
_____	_____	DD/MONTH/YYYY
Printed Name of Referral Source	Signature of Referral Source	Date

Please return this form to:

Intake Coordinator
P.O. Box 2005
35 Boones Road
Corner Brook, NL
A2H 6J7
Telephone: (709) 634-4506, Fax: (709) 634-0160

Name:_____ Date:DD/MONTH/YYYY

Signature:_____

Eastern and Western Health acknowledges and respects the privacy of individuals. The personal information is being collected under the author of sections 29, 30 and 31 of the Personal Health Information Act and will be used for processing your referral application. If you have any questions about the collection of this information, please contact Eastern Health, Regional Access & Privacy office (709) 777-8025. Western Health Regional Access & Privacy Office (709) 637-5000 ext. 5248

Eastern Health

Adult Addictions Inpatient Treatment
REFERRAL APPLICATION
(Part VII)

CL1970 1390 09 2015

Western Health

Name

HCN

Date of Birth

CLIENT SELF ASSESSMENT

(To be completed by Client)

1. Treatment Goals (What do you want to achieve?): _____

2. What are your strengths and weaknesses: _____

3. Do you have a drug plan? ❑ Yes ❑ No

   Insurance Information: _____

Eastern Health

Adult Addictions Inpatient Treatment REFERRAL APPLICATION (Part VIII)

CL1970 1390 09 2015

Western Health

Name

HCN

Date of Birth

CLIENT AGREEMENTS

Please read and sign prior to attending the inpatient treatment centre you have be assigned to. If you have any questions about the agreements, feel free to ask your counsellor.

Client Expectations Agreement: I agree to live up to the following expectations of the inpatient treatment centre to the best of my ability:

1) I will not use alcohol or drugs (except medication prescribed by a doctor or nurse practitioner), or participate in gambling activities while I am in treatment. I understand that failure to do this may result in discharge from the treatment program.

2) I will work to the best of my ability to build a new lifestyle free from my addiction.

3) I will work within the structure of this program, as outlined, and attend the various activities (lectures, films, meetings) at the scheduled time. I understand that it is my responsibility to be present and on time for all scheduled activities. Failure to do this may result in discharge from the treatment program.

4) I will attend all meetings of Alcoholics Anonymous, Narcotics Anonymous, or other self-help groups that are part of the treatment program.

5) I agree that I have a responsibility to my group members and myself and that the situations that are described in group remain in group to protect the trust that group members have for one another.

6) ***I will not borrow money from other residents while involved in the treatment program. I will not lend money to other residents.***

7) I will complete all assignments and hand them in at the designated time.

8) I understand that any kind of violence will not be tolerated. Any threatening, abusive, or hostile behaviour to self or others, will result in immediate action. It could lead to discharge, criminal charges, and, where applicable, invoice for property damage.

9) I will not form an exclusive or sexual relationship with any person while I am involved in treatment. I understand that such behaviour will result in immediate discharge.

10) I understand that at any time, I may be asked by staff to submit to a random urine test for the purpose of an alcohol/drug screening. I understand that refusal to take such a test is grounds for discharge from treatment.

11) I understand that my personal belongings, including my vehicle, will be searched upon admission to, and discharge from, the Centre and may be searched at any point during the program. This is to ensure that the property remains free from addictive substances. I further understand that I will be informed of and present for any such searches. Refusal to consent to such searches will result in discharge.

12) I understand that regular nightly room checks will be conducted by staff during my stay. I agree to wear night attire when going to bed.

Eastern Health

Adult Addictions Inpatient Treatment
REFERRAL APPLICATION
(Part IX)

CL1970 1390 09 2015

Western Health

Name

HCN

Date of Birth

CLIENT AGREEMENTS (Con't)

13) I understand that I will not be permitted to smoke on the centre's property, in keeping with the organization's Smoke Free Policy.

14) I understand that I will not be permitted to wear any scented products while at the Centre.

15) I will dress appropriately at all times. I will not wear T-shirts that may be an indication of my addiction (i.e., beer shirts). I will not wear clothing with sexual comments, foul language etc., which may be offensive to others. I understand that proper footwear will be worn at all times.

16) I understand that at any time, health care professionals may be observing the work being done with clients at the treatment centre. I understand that I will be informed in advance of the presence and identity of the observer and that this person will be bound by rules of confidentiality. This observation may include social/health care and addictions staff and students, sitting in on individual or group sessions or by using a one-way observation mirror and/or audio equipment. The purpose of this observation is to provide staff supervision and training, and to ensure we provide the best possible service to clients.

- ❑ I have read the above expectations, understand their meaning and agree to follow them.
- ❑ I understand that failure to follow these expectations and the rules and regulations that have been explained to me mean that I will be choosing to **discharge** myself from treatment.

_____ DD/MONTH/YYYY _____

Signature of Client Date

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