



Turning Point Recovery Society (1984)
 455 W. 13th Avenue
 Vancouver, BC V5Y 1W4
 Ph: 604-875-1710 F: 604-874-5752

CLIENT NAME

LAST FIRST
PHN _____
DADIC ID _____

REFERRAL FORM

Use additional space on page 3 if required

PART 1 – PERSONAL INFORMATION

Other Names (aliases/nicknames) _____

SIN # _____ **Date Of Birth** ____ / ____ / ____ **Age** ____
DD MM YY

Gender ID M F Transgender

Cultural / Ethnic ID _____ **Other Language(s)** _____

Address _____ Postal Code _____

Contact # 1 _____ 2 _____ **Message** Yes No

Emergency Contact _____ **Message** Yes No
Name Relationship Tel

Dependent Children (enter # of children in box) None reported Living with client Living with separated spouse/partner
 Living with family member In foster care Other _____

Employment Status Full-time Part-time Unemployed

Income Status Employment EI Pension IA IA Application Date _____

Per Diem Coverage Self IA ADS Subsidy Other _____

PART 2 – CURRENT STATUS

Current Situation / Areas of Concern (including crisis or circumstances leading to treatment)

Priority? No In Detox Pregnant Homeless HIV+ /Other Health Issues
 Other Crises _____

Safety Concerns / History or Current Violence in Relationships

Legal None Reported Pending Court Dates _____
 Charges _____
 Convictions Sexual Offences Violent Crimes (eg, weapons, assaults) Living Off Avails of Prostitution
 Outstanding Warrants (what/where) _____
 Probation/Parole (how long/conditions) _____

Know anybody in a support recovery facility now? No Yes Facility Name _____



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PART 3 – PHYSICAL HEALTH

Medical Diagnoses / Major Illnesses

Other Current Physical Health Issues

Communicable Diseases None Reported TB HIV Hep A B or C Other _____

Last Date Tested _____

Pregnant None Reported _____ Weeks Due Date _____ Receiving Pre-Natal Care Yes No

Physician for pre-natal care _____ Tel _____

Relevant Medical History / Prior Hospitalizations

Current Medications (prescription, OTC, supplements)

Name	Condition Being Treated	Current RX Date	How Long on This

Methadone Maintenance Therapy Never

Past **Current**

When _____ How Long on MMT _____

How Long on MMT _____ Current Dose _____

Dose _____ Maintenance Reduction Carry Privileges Yes No

Prescribing Physician _____ Name _____ Tel _____

Allergies (drug, food, environmental – include reactions) _____

Special Needs / Disabilities _____

Special Aids Used _____



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PART 5 - ADDICTIONS

Substance Use History Fill in for each substance Enter "0" if not applicable	Method: 1 = Oral 2 = Snort/Sniff 3 = Smoke/Chase 4 = Intravenous 5 = Intramuscular	Amount	Frequency	Years of Use	Date Last Used
Alcohol					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Crack					
Crystal Meth					
Ecstasy					
Hallucinogens					
Heroin					
Illicit Methadone					
Inhalants					
Nicotine					
Opiates other than heroin/methadone					
Misuse of other Prescription Meds					
Speedball (Cocaine/Heroin)					

Other Addictions (sex, food, gambling, etc)

Previous Addictions Support / Treatment

Agency (Name)	Dates	Outcomes	Comments



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PART 6 - PROFESSIONALS INVOLVED

	Name	Agency / Office	Tel
Physician (G.P.)			
Addictions Physician			
Psychiatrist			
Mental Health Team			
A & D Counselling			
Health Centre			
Dual Diagnosis			
IA (MEIA)			
MCFD Social Worker			
Legal			
Parole / Probation			
Other Counsellor			

PART 7 - VERIFICATION

Client Preference for Support Recovery (enter numbers 1-3 in order of preference)	Central City Lodge (M) _____	Together We Can (M) _____	Turning Point (M/F) _____
	Homestead (F) _____	New Dawn (F) _____	
	Other _____		

Client Authorization	
I _____, verify that the information provided here is true to the best of my knowledge. <small>Print Name</small>	
I understand that the information in this assessment will be shared with Vancouver Coastal Health professional staff involved in my care, and with the support recovery facilities identified above.	
Client Signature _____	Date ____/____/____ <small>DD MM YY</small>

Staff Verification	
Completed by _____ <small>Please Print</small>	Site _____
Staff Signature _____	Date ____/____/____ <small>DD MM YY</small>