



Turning Point Recovery Society (1984)  
 10411 Odlin Road  
 Richmond BC, V6X 1E3  
 Ph: 604-303-6717 F: 604-303-7646

<b>CLIENT NAME</b>	_____	_____
	LAST	FIRST
<b>PHN</b>	_____	
<b>PARIS ID</b>	_____	

## REFERRAL FORM

Use additional space on page 3 if required

### PART 1 – PERSONAL INFORMATION

<b>Other Names</b> (aliases/nicknames) _____	
<b>SIN #</b> _____	<b>Date Of Birth</b> _____ / _____ / _____ <b>Age</b> _____
	DD                      MM                      YY
<b>Gender ID</b>	M <input type="checkbox"/> F <input type="checkbox"/> Transgender <input type="checkbox"/>
<b>Cultural / Ethnic ID</b> _____	<b>Other Language(s)</b> _____
<b>Address</b> _____	
	Postal Code
<b>Contact #</b> 1 _____ 2 _____	Message <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Emergency Contact</b> _____	Message <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name                      Relationship                      Tel
<b>Dependent Children</b> (enter # of children in box)	None reported <input type="checkbox"/> Living with client <input type="checkbox"/> Living with separated spouse/partner <input type="checkbox"/>
	Living with family member <input type="checkbox"/> In foster care <input type="checkbox"/> Other _____
<b>Employment Status</b>	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/>
<b>Income Status</b>	Employment <input type="checkbox"/> EI <input type="checkbox"/> Pension <input type="checkbox"/> IA <input type="checkbox"/> IA Application Date _____
<b>Per Diem Coverage</b>	Self <input type="checkbox"/> IA <input type="checkbox"/> ADS Subsidy <input type="checkbox"/> Other _____

### PART 2 – CURRENT STATUS

<b>Current Situation / Areas of Concern</b> (including crisis or circumstances leading to treatment)	
<b>Priority?</b>	No <input type="checkbox"/> In Detox <input type="checkbox"/> Pregnant <input type="checkbox"/> Homeless <input type="checkbox"/> HIV+ /Other Health Issues <input type="checkbox"/>
Other Crises _____	
<b>Safety Concerns / History or Current Violence in Relationships</b>	
<b>Legal</b>	None Reported <input type="checkbox"/> Pending Court Dates _____
Charges _____	
Convictions      Sexual Offences <input type="checkbox"/> Violent Crimes (eg, weapons, assaults) <input type="checkbox"/> Living Off Avails of Prostitution <input type="checkbox"/>	
Outstanding Warrants (what/where) _____	
Probation/Parole (how long/conditions) _____	
<b>Know anybody in a support recovery facility now?</b>	No <input type="checkbox"/> Yes <input type="checkbox"/> 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 4 – MENTAL HEALTH**

<p><b>Mental Health History / Symptoms</b> (include psychiatric diagnoses, hospitalizations, other treatment)</p>          <p><b>Self-Harming Behaviours</b> (eating disorders, slashing, burning)</p>          <p><b>Suicide Risk</b>    current <input type="checkbox"/>    ideation <input type="checkbox"/>    previous attempts <input type="checkbox"/>    details _____</p>    <p><b>Current Mood / Presenting Symptoms</b></p> <p>Reported: _____</p> <p>                  _____</p> <p>Observed: _____</p> <p>                  _____</p>
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*Continue to next section                      OR                      Use this space for additional notes*



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**PART 5 - ADDICTIONS**

<b>Substance Use History</b> Fill in for each substance Enter "0" if not applicable	<b>Method:</b> 1 = Oral 2 = Snort/Sniff 3 = Smoke/Chase 4 = Intravenous 5 = Intramuscular	<b>Amount</b>	<b>Frequency</b>	<b>Years of Use</b>	<b>Date Last Used</b>
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**

<b>Agency (Name)</b>	<b>Dates</b>	<b>Outcomes</b>	<b>Comments</b>



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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**

<b>Client Preference for Support Recovery</b> (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 _____		

<b>Client Authorization</b>	
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.	
<b>Client Signature</b> _____	<b>Date</b> ____ / ____ / ____ <small>DD MM YY</small>

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