TP Vancouver (TP-V) Fax 604-874-5752
TP Richmond Mens (TPRM) Fax 604-303-7646
TP Richmond Womens (TPRW) Fax 604-284-5421
TP NS Womens (TPNSW) Fax 604-973-0151

CLIENT NAME ______________________________
LAST FIRST

Date of Birth ____ / ____ / ____ **Current Age** _____
DD MM YY

BRIEF ASSESSMENT / REFERRAL FORM

SITE: TP-V TPRM TPRW TPNSW
Please circle

Use additional space on page 3 if required

PART 1 – PERSONAL INFORMATION

Other Names (aliases/nicknames) ______________________________

SIN # ____________________ **PHN #** ____________________

Gender Identification M ☐ F ☐ Transgender ☐ → FTM ☐ MTF ☐

Ethnic Identification ____________________ **Other Language**(s) ____________________

Address ______________________________
Postal Code

Contact # 1 ____________________ 2 ____________________ Message ☐ Yes ☐ No

Emergency Contact ____________________ ____________________ ____________________ Message ☐ Yes ☐ No
Name Relationship Tel

Next of Kin ____________________ ____________________ ____________________ 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 ☐ EI / IA Application Date ____________________

Funding Source 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 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, over-the-counter, supplements)

Name	Condition Being Treated	Current RX Date	How Long on This

Methadone Maintenance Therapy (MMT) **Never** ☐

Past ☐
When __________________________
How Long on MMT __________________________
Dose __________________________

Current ☐
How Long on MMT __________________________
Current 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

Mental Health History / Symptoms (include psychiatric diagnoses, hospitalizations, other treatment)

Self-Harming Behaviours (eating disorders, slashing, burning)

Suicide Risk current ☐ ideation ☐ previous attempts ☐ details ____

Current Mood / Presenting Symptoms

Reported: ____

____

Observed: ____

____

Continue to next section *OR* *Use this space for additional notes*

Additional Information:

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CLIENT NAME ____________________
LAST FIRST

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DD MM YY

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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CLIENT NAME ____
LAST FIRST

Date of Birth _____ / _____ / _____ **Current Age** _____
DD MM YY

PART 6 - PROFESSIONALS INVOLVED

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

PART 7 - VERIFICATION

Client Authorization

I ____________________________________, verify that the information provided here is true to the best of my knowledge.
Print Name

I understand and consent to the release of the information in this assessment to Vancouver Coastal Health professional staff and Turning Point Recovery Society.

Client Signature ____ **Date** _____/_______/_______
DD MM YY

Staff Verification

Completed by ____ Site ____
Please Print

Staff Signature ____ Date _____/_______/_______
DD MM YY