Amethyst House
280 2nd Street, Courtenay BC V9N 1B6
250-871-2570 |fax 250-871-2573 | www.amethysthouse.ca

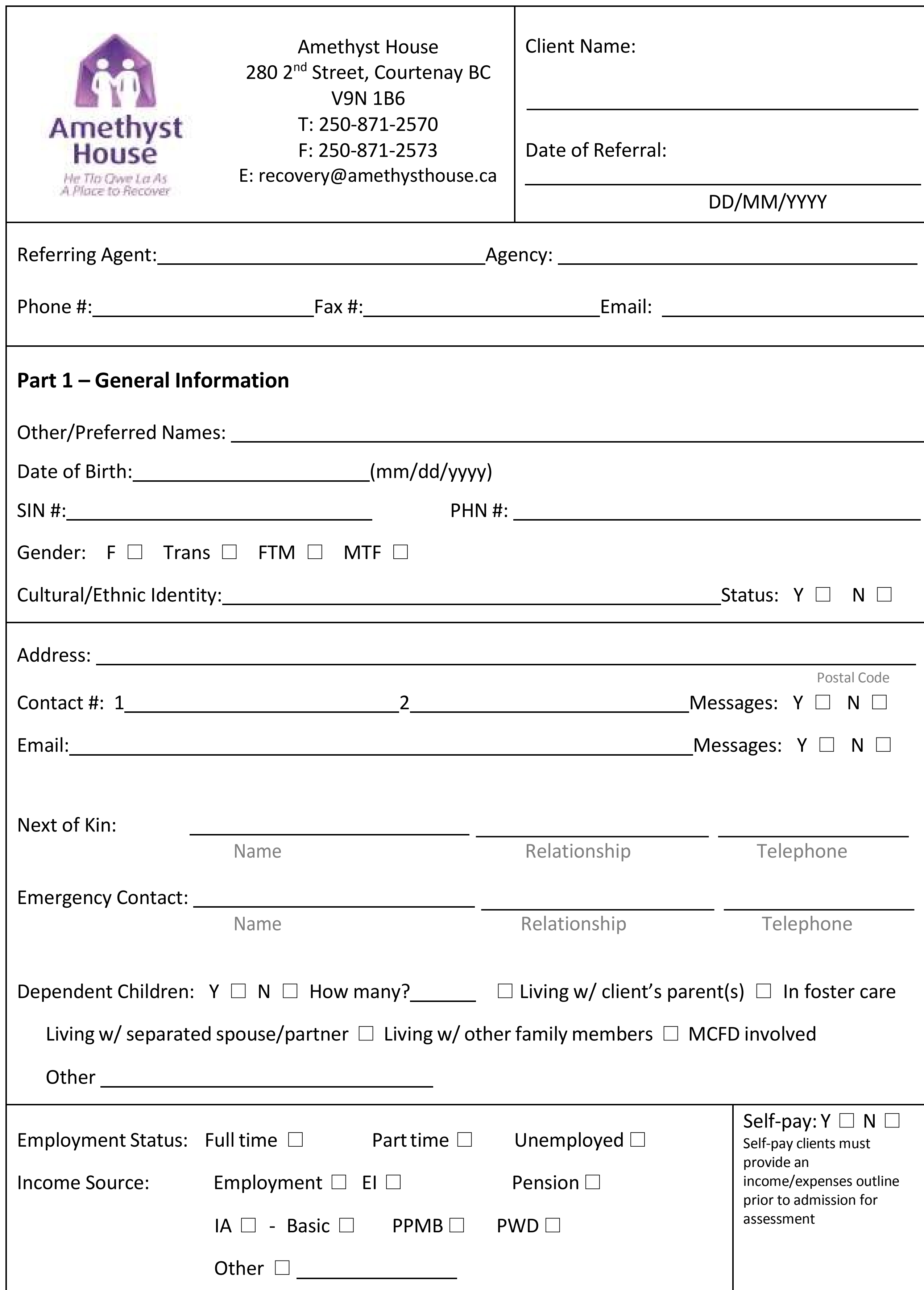
Referring Agent Check List

Ensuring that your client is fully informed will contribute to her having as successful a stay at Amethyst as is possible. Please review the following with your client prior to their arrival:

- □ Referral form
- □ Review and signing of AH Guidelines
- □ What you need to Know
- □ Reasons for Discharge from AH
- □ Medications- insuring client is medically stable and all medications that come to Amethyst House are blister-packed
- □ Funding verification
- □ Reviewing that Amethyst House is a Supportive Recovery program and not a treatment program
- □ Program: □ 30 day □ 60 day □ 90 day

Please note: If wanting an extension to your 30 day program the request must be submitted by Day 15

CONFIDENTIAL REFERRAL FORM



Amethyst House
He Tla Qwe La As
A Place to Recover

Amethyst House
280 2nd Street, Courtenay BC
V9N 1B6
T: 250-871-2570
F: 250-871-2573
E: recovery@amethysthouse.ca

Client Name: ______________________________

Date of Referral: ______________________________
DD/MM/YYYY

Referring Agent: ______________________________ Agency: ______________________________

Phone #: ____________________ Fax #: ____________________ Email: ____________________

Part 1 – General Information

Other/Preferred Names: ____

Date of Birth: ____________________ (mm/dd/yyyy)

SIN #: ____________________ PHN #: ____________________

Gender: F ☐ Trans ☐ FTM ☐ MTF ☐

Cultural/Ethnic Identity: ______________________________ Status: Y ☐ N ☐

Address: ____
Postal Code

Contact #: 1 ____________________ 2 ____________________ Messages: Y ☐ N ☐

Email: ______________________________________ Messages: Y ☐ N ☐

Next of Kin: ____________________ ____________________ ____________________
Name Relationship Telephone

Emergency Contact: ____________________ ____________________ ____________________
Name Relationship Telephone

Dependent Children: Y ☐ N ☐ How many? ______ ☐ Living w/ client's parent(s) ☐ In foster care

Living w/ separated spouse/partner ☐ Living w/ other family members ☐ MCFD involved

Other ______________________________

Employment Status: Full time ☐ Part time ☐ Unemployed ☐

Income Source: Employment ☐ EI ☐ Pension ☐

IA ☐ - Basic ☐ PPMB ☐ PWD ☐

Other ☐ ____________________

Self-pay: Y ☐ N ☐
Self-pay clients must provide an income/expenses outline prior to admission for assessment

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

____

What current indicators lead you to assess this client as being eligible and emotionally ready for stabilization/supported recovery programming within a communal-living environment?

Safety Concerns/History or Current Violence in Relationships/Client Has Been Violent with Others

Restraining Orders/No Contact Orders: Y ☐ N ☐ Required ☐

Victims Services Involvement: Y ☐ N ☐ Required ☐

Legal Concerns: ____

Any other information relevant to this client: ____

Part 2 – Medical Information

Medications Currently Taking (prescription/over the counter/supplements):

Name	Current Dosage	Condition Treated	Taken for How Long

Medical Diagnosis/Major Illness

____

____

____

Other Current Physical/Health Concerns

____

____

____

Communicable Diseases:

TB ☐ HIV ☐ Hep A B or C ☐ Other: ______________________________

Date Last Tested: ______________________________

Pregnancy: Y ☐ N ☐ ________Weeks Due Date: ______________________________

Family Physician: Y ☐ N ☐ Name: ______________________________

Methadone Maintenance Therapy (MMT):

Never ☐

Past ☐

When: ______________________

How Long on MMT: ____

Dose ______________________

Current ☐

How Long on MMT ______

Current Dose ____________________________

Maintenance ☐ Reduction ☐

Carry Privileges Y ☐ N ☐

Prescribing Physician ________________________________ Tel _________________________________

Allergies (drug, food, environmental – include reactions and remedies ie: inhaler, antihistamine):

____

____

____

____

____

Special Needs/Challenges: ____

Special Aid(s) Used/Required: ____

Special Dietary Needs: ____

Additional Information about Health Concerns:

____

____

____

____

____

____

Part 3 – Mental Health

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

____
____
____
____
____
____

Self-Harming Behaviours (include eating disorders, cutting, burning, other):

____
____
____
____

Suicide Risk: Current ☐ Ideation ☐ Previous attempts ☐

Please provide details: ____
____
____

Additional Information on Mental Health Concerns:

____
____
____
____
____
____

Part 4 - Substance Use/ Misuse History:

In the past year what substances have you used/ misused and what is the date of your last use for each substance?

Substance	Date of Last Use

Other Addictions (sex, food, gambling, etc.)

___

___

Amethyst House
280 2nd Street, Courtenay BC V9N 1B6
T: 250-897-0511 F: 250-897-0595
E: admin@cvts.ca

Client Authorization: My signature below verifies that the information I have provided to the Referring Agent noted below for the purposes of this referral and my application for residence within Amethyst House's program(s) is accurate to the best of my knowledge. My signature also authorizes the release and/or exchange of information between Amethyst House staff and all service providers noted below. This authorization is valid for pre-admission collaboration of care purposes (including a discharge summary) and for the entire duration of my residence within Amethyst House.

______________________________ Client Signature

______________________________ Date: dd/mm/yyyy

Referring Agent Identification/Verification:

______________________________ Print Name

______________________________ Date: dd/mm/yyyy

______________________________ Signature

______________________________ Agency/Organization

Service Provider	Name	Agency	Phone or email
Physician (GP)			
Addictions Counsellor			
Addictions Physician			
Psychiatrist			
Mental Health Worker			
Other Counsellor			
Probation/Parole Officer			
Income Assistance			
MCFD Worker			
Lawyer			
Other			
Other			
Other			

AMETHYST HOUSE

Early Exit Transition Plan

It is understood that if I leave the program, am discharged early or if I do not arrive for my scheduled intake at Amethyst House, my referral liaison and/or my early/emergency contact will be notified. I must also have a plan in place for shelter and transport prior to admission

Client name:	Date of Birth: dd/mm/yyyy
Early Exit Plan:	
Transportation plan and cost:	

Community Contact for Early Exit Support:

My emergency contact will also be contacted if I need to stay overnight at the hospital.

Name of Contact for Early Exit Plan:	Telephone: ______________________________ Email: __________________________________
Name of Emergency Contact:	Telephone: ______________________________ Email: __________________________________

I agree that I am responsible for all transportation costs and that 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: dd/mm/yyyy ____
Worker signature: ____	____