

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

 <p style="text-align: center;"> Amethyst House 280 2nd Street, Courtenay BC V9N 1B6 T: 250-871-2570 F: 250-871-2573 E: recovery@amethysthouse.ca </p>	Client Name: _____ Date of Referral: _____ <p style="text-align: center;">DD/MM/YYYY</p>												
Referring Agent: _____ Agency: _____ Phone #: _____ Fax #: _____ Email: _____													
Part 1 – General Information Other/Preferred Names: _____ Date of Birth: _____ (mm/dd/yyyy) SIN #: _____ PHN #: _____ Gender: F <input type="checkbox"/> Trans <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Cultural/Ethnic Identity: _____ Status: Y <input type="checkbox"/> N <input type="checkbox"/>													
Address: _____ <p style="text-align: right; margin-right: 50px;"><small>Postal Code</small></p> Contact #: 1 _____ 2 _____ Messages: Y <input type="checkbox"/> N <input type="checkbox"/> Email: _____ Messages: Y <input type="checkbox"/> N <input type="checkbox"/>													
Next of Kin: _____ <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center;">Name</th> <th style="width: 25%; text-align: center;">Relationship</th> <th style="width: 25%; text-align: center;">Telephone</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> Emergency Contact: _____ <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center;">Name</th> <th style="width: 25%; text-align: center;">Relationship</th> <th style="width: 25%; text-align: center;">Telephone</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Name	Relationship	Telephone	_____	_____	_____	Name	Relationship	Telephone	_____	_____	_____
Name	Relationship	Telephone											
_____	_____	_____											
Name	Relationship	Telephone											
_____	_____	_____											
Dependent Children: Y <input type="checkbox"/> N <input type="checkbox"/> How many? _____ <input type="checkbox"/> Living w/ client's parent(s) <input type="checkbox"/> In foster care Living w/ separated spouse/partner <input type="checkbox"/> Living w/ other family members <input type="checkbox"/> MCFD involved Other _____													
Employment Status: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Income Source: Employment <input type="checkbox"/> EI <input type="checkbox"/> Pension <input type="checkbox"/> IA <input type="checkbox"/> - Basic <input type="checkbox"/> PPMB <input type="checkbox"/> PWD <input type="checkbox"/> Other <input type="checkbox"/> _____	Self-pay: Y <input type="checkbox"/> N <input type="checkbox"/> 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):

Past Never
Current
When: _____ How Long on MMT _____
How Long on MMT: _____ Current Dose _____
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:



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 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.

_____ Date: dd/mm/yyyy
 Client Signature

Referring Agent Identification/Verification:

_____ Date: dd/mm/yyyy
 Print Name

_____ Agency/Organization
 Signature

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: _____ Worker signature: _____	Date: dd/mm/yyyy _____ _____
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