280 2nd Street
Courtenay, BC
V9N 1B6
Ph: 250-871-2570
Fax: 250-871-2573
email: *ahadmin@cvts.ca*

Amethyst House
He Tlo Qwe La As • A Place to Recover

AMETHYSE HOUSE REFERRAL PACKAGE

Referring Agent Check List

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

- ☐ Referral package.
- ☐ Review and signing of Amethyst House Guidelines.
- ☐ What you need to know.
- ☐ Reasons for discharge from Amethyst House.
- ☐ Medications- insuring client is medically stable and all medications that come to Amethyst House are blister-packed.
- ☐ Funding verification on referral package
- ☐ Reviewing that Amethyst House is a Supportive Recovery program and not a treatment program.
- ☐ Program duration desired:

  □ 30 day □ 60 day □ 90 day

Please note:
If you are wanting an extension to your 30-day program the request must be submitted within the first 15 days of your stay at Amethyst House. *To receive the full benefits of the program, it is recommended to complete the 90-day.*

CONFIDENTIAL REFERRAL FORM

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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:** YES ☐ NO ☐

Address: _____ **Postal Code:** _____

Contact #: 1) _____ **2)** _____ **Messages:** YES ☐ NO ☐

Email: _____ **Messages:** YES ☐ NO ☐

Next of Kin: _____ _____ _____
Name Relationship Telephone

Emergency Contact: _____ _____ _____
Name Relationship Telephone

Dependent Children: YES ☐ NO ☐ 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 ☐ E.I. ☐ Pension ☐
Income Assistance ☐ Basic ☐ PPMB ☐ PWD ☐
Other ☐ _____

Self-Pay: YES ☐ NO ☐
Self-pay clients must provide an income/expense 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: Yes ☐ No ☐ Required ☐

Victims Services Involvement Yes ☐ No ☐ 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: Yes ☐ No ☐ Weeks: _____ Due Date: _____

Family Physician: Yes ☐ No ☐ Name: _____

Methadone Maintenance Therapy (MMT):

Never ☐

Past ☐ **Current ☐**

When: _____ **How long on MMT: _____**

How Long on MMT: _____ **Current Dose: _____**

Dose: _____ **Maintenance ☐** **Reduction ☐**

Carry Privileges: Yes ☐ No ☐

Prescribing Physician: _____ Tel: _____

Allergies (drug, food, environmental – include reactions and remedies, i.e. 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.)

_____

_____

_____

_____

_____

_____

_____

_____

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Part 5 – Release of Information (ROI)

Client Authorization: My signature below verifies that the information I have provided to the Referring Agent noted below is 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 the 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 AND/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			

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Part 6 – EARLY EXIT TRANSITION PLAN

It is understood that if I leave Amethyst House 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/YYY
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: _____ Date: DD/MM/YYYY _____

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Part 7 – MSDSI FUNDING VERIFICATION – *Must be signed by the client*

Date: _____

To: Ministry of Social Development & Social Innovation **Fax #:** _____

From: _____ **Fax #:** _____

Client Name: _____ **DOB:** _____/____/_____
DD / MM / YYYY

SIN: _____

This person has been referred for admission to Amethyst House Residential Stabilization and Supportive Recovery Services. Prior to admission we require confirmation that the client's per diem costs (less any non-exempt income) will be paid by MSDSI while in receipt of and eligible for income assistance. Once the client has been admitted we will send an admission report.

Income from Other Source(s): $_____ Source: _____

Client Authorization: I, _____ authorize the Ministry of Social Development & Social Innovation to confirm eligibility for funding and to release any related information to Amethyst House staff.

_____ _____
Client Signature Date

MINISTRY OF SOCIAL DEVELOPMENT & SOCIAL INNOVATION - VERIFICATION

☐ Client has an open and active file
☐ Client eligibility to be determined
☐ Client file has been closed
☐ Client is eligible for funding as follows:

Comments:

Client's monthly per diem will be paid by MSDSI as per current eligibility less and non-exempt income from other sources as follows:

Clients contribution (non exempt income) $_____

Non exempt income from: _____

Maximum Amount Payable by MSDSI per Month $_____

MSDSI Contact Name: _____
Tel/Fax: _____
Email: _____
Date: _____

Place Office Stamp Here