CONFIDENTIAL REFERRAL FORM

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

Client Name: _____

Date of Referral: _____
DD/MM/YYYY

Referring Agent: _____ Agency: _____

Phone #: _____ Fax #: _____ Email: _____

Part 1 – General Information

Other/Preferred Names:

_____ SIN #:

_____ PHN #: _____

Gender: _____ Preferred Pronouns: _____

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

Address:

_____

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 ☐
Monthly Room & Board rates at Amethyst House are on a sliding scale. 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 ☐ 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:

_____

_____

_____

_____

_____

_____

Part 4 – Substance Use/Misuse History

Substance	Method	Years of Use	Frequency	Date of Last Use
Alcohol				
Barbiturates				
Benzodiazepines (illicit or prescribed)				
Cannabis				
Club Drugs (GHB, Ketamine)				
Cocaine				
Crack				
Crystal Meth				
Ecstasy/MDMA				
Hallucinogens				
Heroin				
Inhalants				
Methadone/Methadose (illicit)				
Nicotine/Tobacco				
Opiates (other than heroin or methadone)				
Opiates (prescribed)				
Other Prescription Meds Misuse				
Other				

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

_____

_____

_____

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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 and collaboration of care purposes and for the entire duration of my residence within Amethyst House and at no other time.

_____ _____

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			

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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 Recovery residential addictions program. 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 and admission report.

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

Client Authorization: I, _____ authorize the Ministry of Social Development & Social Innovation to confirm my 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 any non-exempt income from other sources as follows:

Client contribution (non-exempt income) $ _____
Non-exempt income from _____
Maximum Amount Payable by MSDSI per Month $ _____

MSDSI Contact Name: _____

Tel/Fax: _____ Place Office Stamp Here

Email: _____

Date: _____