**SOAR Bed-Based and Day Treatment Services**

**Referral Package**

*All referrals require a consent to disclose and consent to obtain signed by both the client and the referring party.*

If the client has completed a recent GAIN Q3 MI ONT or ADAT assessment, please attach it to the referral. If not, only the referral form and consent is required.

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| Referral for: Bed-Based Treatment Day Treatment | | | |
| DEMOGRAPHICS | | | |
| First Name: | Last Name: | D.O.B yyyy/mm/dd: | Gender: |
| Health Card Number: | Address (Street, City, Postal Code):  (Is this address any of the following):  No  Shelter NFA Supportive/Transitional Housing | | |
| Email: | Phone Number:  Permission to:  Call Leave Voicemail  Text | | |
| Languages Spoken and Understood:  Preferred Language for Services: | | | |
| **Referral Source:** | **Referring Party’s Name:** | **Referring Party’s Phone Number:** | **Referring Party’s Email:** |

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| PHYSICAL HEALTH SCREENING | |
| Does the client have any physical health diagnoses? Yes No  If yes, please describe: | Does the client have any allergies?  Yes No  If yes, specify: |
| Has the client’s physical health prevented them from completing tasks of daily living within the past three months? (Ex. eating, chores, bathing, toileting) Yes No  If yes, please describe: | In relation to the client’s physical health, is there any concern for the client’s ability to maneuver group dynamics in a classroom setting or in a group living environment? Yes No  If yes, specify: |
| Is the client currently struggling with any of the following:  Vision  Hearing  Mobility | Is there any chance the client could be pregnant?  Yes  No |
| Has the client had any hospital visits within the past three months in relation to physical health? Yes No  If yes, what for? | Does the client have any ongoing specialist appointments, surgeries, or procedures that may occur within the next three months? Yes No  If yes, note date/time and purpose of appointment: |
| MENTAL HEALTH SCREENING | | |
| Does the client have any mental health diagnoses? Yes No  If yes, describe: | | |
| Is the client currently receiving any treatment for mental health? Yes No If yes, specify. | How often in the past three months has the client struggled with their mental health symptoms?  ☐Monthly  ☐Weekly  ☐Multiple times weekly  ☐Daily  ☐Multiple times daily | |
| Has the client’s mental health kept them from maintaining their daily responsibilities within the past three months? Yes No  If yes, describe: | Would the client’s current mental health inhibit their ability to manage group dynamics in a classroom setting or in a group living environment? Yes No  If yes, specify: | |

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| Medication List | | | | | | |
| Medications | Dose | | Reason | | | Comments (including if taking them as prescribed) |
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| Have you experienced any of the following in the past 12 months? | | | | | | | |
| Issue | | Yes | | No | Please describe (including coping strategies, safety plan, etc.) | | |
| Anxiety | |  | |  |  | | |
| Depression | |  | |  |  | | |
| Difficulty Sleeping | |  | |  |  | | |
| Fears/Phobias | |  | |  |  | | |
| Feeling that people are against you or trying to harm you | |  | |  |  | | |
| Feeling aggressive/violent towards others | |  | |  |  | | |
| Seeing or hearing things that are not there | |  | |  | If yes, are these things disturbing?  Yes No  Is the client aware of when they are happening? Yes No | | |
| Self-Harm Behavior | |  | |  | How? When? | | |
| Thoughts of Suicide | |  | |  |  | | |
| Suicide Attempt(s) | |  | |  | If yes, when? | | |
| Financial Concerns | |  | |  | When? | | |
| Eating Disorders: Does the client have disordered eating behaviour (i.e. eating disorder)? Yes No  If yes, respond to the following questions: | | | | | | |
| Does the client’s eating behaviour negatively affect their activities of daily living? | | | | | | |
| How would the client’s eating habits be affected by group living dynamics? | | | | | | |

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| SUBSTANCE USE | | | | |
| What substances has the client used in the past 12 months and how frequently do they use them? | | | | |
| **Substance** | **Frequency** | **Typical Quantity** | **Method of Use** (ORAL, INHALATION, INJECTION) | **Last Use** |
|  | Monthly  Weekly  Multiple times weekly  Daily  Multiple times daily |  |  |  |
|  | Monthly  Weekly  Multiple times weekly  Daily  Multiple times daily |  |  |  |
|  | Monthly  Weekly  Multiple times weekly  Daily  Multiple times daily |  |  |  |
|  | Monthly  Weekly  Multiple times weekly  Daily  Multiple times daily |  |  |  |
|  | Monthly  Weekly  Multiple times weekly  Daily  Multiple times daily |  |  |  |
| Are there any substances that the client has successfully recovered from (abstained/reduced)?  Yes No  If yes, describe: | | | Has the client been hospitalized due to substance use, withdrawal, or opioid poisoning in the past three months? Yes No  If yes, specify: | |
| Has the client attended substance use services/treatment in the past? Yes No  If yes, please specify: | | | | |

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| LEGAL | |
| Does the client currently have any legal issues? Yes No  If yes, select all that apply:   * Probation * Parole * Bail * Awaiting Trial * House Arrest * Incarcerated * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Are the client’s legal issues related to weapons, violence, or arson? Yes No If yes, specify. |

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| SOCIAL SUPPORTS | |
| Does the client currently have support from family/friends/community? Yes No If yes, please describe: | |
| READINESS FOR CHANGE | |
| On a scale of 1 to 10, with 1 being ‘not at all’ and 10 being ‘very’, how important is it for the client to change their substance use?  Scale 1 10 Royalty-Free Images, Stock Photos & Pictures | Shutterstock | On a scale of 1 to 10, with 1 being ‘not at all’ and 10 being ‘very’, how confident is the client in their ability to make changes to their substance use?  Scale 1 10 Royalty-Free Images, Stock Photos & Pictures | Shutterstock |
| Is anyone mandating or pressuring the client to attend treatment? Yes No  If yes, who and why? | |

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| Post Bed-based Treatment Support Plan |
| What is the client’s care plan post bed-based treatment services? Will the client maintain connection to their referring party? |