



VCH YOUTH AND YOUNG ADULT (17-24 YO) STABILIZATION BED REFERRAL FORM

STAFF REFERRAL INFORMATION

Referral Date:		Date Sent to Service Provider:	
Referring Staff Name:		Referring Organization:	
Phone Number:		Email Address:	

CLIENT INFORMATION

Legal Name:		Preferred Name:		Preferred Pronoun	
Date of Birth mm/dd/yyyy		Age		Gender	
Social Insurance Number		Personal Health #			
Current Address:		City			
Province		Postal Code:			
Phone:		Email:		Is it OK to leave a message?	
Emergency Contact:		Emergency Phone Number:			
Does the client identify as Indigenous (<i>First Nations, Metis or Inuit</i>)?					
If YES:					
<input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> First Nations & Inuit <input type="checkbox"/> First Nations & Metis <input type="checkbox"/> Metis & Inuit <input type="checkbox"/> Metis & Inuit <input type="checkbox"/> Outside of Canada <input type="checkbox"/> No Response <input type="checkbox"/> Unknown					
Does the client have status / Citizenship?		Where does the client live predominantly?			
Status Card #:		Band:			



FAMILY INVOLVEMENT

Does the client have any family members they wish to be involved in their care?
(if YES, please list below)

Name:		Relationship:		Contact Information:	
Name:		Relationship:		Contact Information:	
Name:		Relationship:		Contact Information:	
Name:		Relationship:		Contact Information:	

Does the client have any children?
(please list name and age below)

Name:		Relationship:		Age:	
Name:		Relationship:		Age:	
Name:		Relationship:		Age:	
Name:		Relationship:		Age:	

Is the client a custodian parent of any child(ren)?

Can they be supported with visits?

Is the client's child(ren) under the care of the Ministry of Child and Family Development?

(if YES, please provide details below including the contact information of the current social worker / custodial parent(s):



POST STABILIZATION PLAN

Is there a current post stabilization plan?

Have referrals been completed for other programs?

If YES, please list below:

What are the client's current treatment / recovery goals and how can they be supported while in stabilization?

SUBSTANCE USE AND OTHER PROCESS ISSUES / CONCERNS

Please select any substances that the client has used or has had a history with:

- Alcohol Non-Beverage Alcohol Amphetamines Ecstasy GHB Benzodiazepines
- Cannabis Cocaine Crack Cocaine Crystal Meth Fentanyl Hallucinogens Heroin
- Inhalants Other Opioids Tobacco / Nicotine (*including vaping/e-cigarettes*) Other (*specify below*)

Please list the top three (3) substances of choice and current pattern of usage

	Substance of choice	Date last used	#Days used within last 30 days	Route of use (<i>oral, inhalation, IV, etc</i>)	Average amount of use	Age of first use
1						
2						
3						

Please select any of the following that the client feels are current or have previous history with:

- Gambling Sexual Activity Pornography Shopping Shoplifting Internet Gaming
- Social media Other (*please note below*)



SUBSTANCE USE TREATMENT HISTORY

Has the client ever attended the following:

- Withdrawal Management (detox) Peer Support Group (*AA/NA/SMART*)
 Community Counsellor/Support Program Residential Substance Use Treatment
 Day Treatment Program None Other (*specify below*)

MEDICAL HISTORY

Is the client currently independent with activities of daily living?

Does the client currently require withdrawal management?

(*required for recent/significant use of alcohol, benzodiazepines, fentanyl and heroin*)

Does the client experience adverse withdrawal systems?

(*seizures, delirium tremens, etc.*)

If YES, please specify:

Does the client have any allergies?

(*Environmental, food or medication*)

Please list below:

Is there a history of disordered eating? ‘

Is it still active?

Is there any history of treatment for eating disorders?

Are there any dietary concerns or requirements?

(*if YES, please list below*)



Are there any other health or mobility issues?	
Any current mobility aids or further care?	
If YES, please specify:	

Please indicate if any of the following are applicable to the client:
<input type="checkbox"/> Fall Risk <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis (A-B-C) <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Prosthesis <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Impairment

MENTAL HEALTH HISTORY

Please list any diagnosed or self-reported mental health concerns.

CURRENT MEDICATIONS

Please list all current medications and their dosage that the client is currently utilizing.

Is the client on any injectables? Please note date of the next required dosage. <i>(or attach a medication administration record to the referral)</i>	



LEGAL / SAFETY CONCERNS

Please indicate if any of the following are applicable to the client.

- Self Harming Behaviours Suicidal Ideation Noted Flight Risk Sex Work
- Sexual Offences (*adult / minor*) Arson/Fire Setting Interpersonal/Domestic Violence
- Verbal Aggression Physical Aggression Suicide Attempt(s) # of attempts

Does the client have any current legal involvement (*i.e., probation, bail order, conditions*)?

Please provide contact details of probation / bail officer:

Is the client currently certified under the BC Mental Health Act or on Extended Leave?

If YES - BC Mental Health Act - please attach Form 4 or 6

If YES - Extended Leave - please attach Form 4, 6 and 20

EARLY EXIT / TRANSITION PLANNING

Should the client want to leave stabilization early or otherwise be asked to leave, we will utilize their early exit plan. Please provide the address, transportation plan, name and contact information of their safety / supportive exit location.

Is the contact provided aware they are the early exit plan?

Is this the same on evening and weekends?

(if no, please provide alternate contact name and phone number)



By signing below, I consent to the following:

This referral is being submitted for consideration for the Vancouver Coastal Health Youth and Young Adult Stabilization Program at the Phoenix Society. The information in this referral and any supporting documentation being released and shared between my community care team, Vancouver Coastal health and Phoenix Society. As part of my treatment application, I have provided accurate information to the best of my ability, voluntarily agree to attend the program and understand that this is a substance free program.

Should I choose to leave the program early, my community care team, Vancouver Coastal Health and my emergency contact will be contacted and provided with an update. By signing below, I consent to my referral liaison and emergency contact being contacted should I be accepted to the program.

Please fax completed referrals to 604-951-1191 or send via email to phoenixaccessandflow@phoenixsociety.com via password protected email with the password sent separately for confidentiality purposes.

Applicant Name:		Signature:		Date:	
-----------------	--	------------	--	-------	--

Referral Provider Name		Signature:		Date:	
------------------------	--	------------	--	-------	--