Newfoundland Labrador

Name: _____

HCN: _____

Date of Birth: _____

Adult Addictions Inpatient Treatment

REFERRAL ASSESSMENT (Part I)

Date of Referral: _____

Thank you for referring your client to Addictions Inpatient Treatment. All sections of this assessment must be completed prior to sending to our intake coordinator. The Medical Assessment must be included and cannot be sent separately.

Please indicate if the items below have been completed and attached.

- ☐ Referral Assessment
- ☐ Medical Assessment and signatures
- ☐ Client Expectations agreement and signatures
- ☐ Health care number and expiry date

A staff person will telephone the client one week before their admission date to confirm their attendance, answer any questions they may have, and provide them with additional information about the program.

If not at home, may we leave a message? ☐ Yes ☐ No

If an alternate person will be coordinating this referral after this assessment has been sent please provide the name and telephone number of that person:

Name: _____

Contact Number: _____

Name and Professional Designation: _____ Date: _____

Signature: _____

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Adult Addictions Inpatient Treatment

REFERRAL ASSESSMENT (Part II)

Client Information

Clients Name:		Gender:
Mailing Address:		
City/ Town:		Postal Code:
Mobile Number:	Home Phone:	
Email Address:		
Date of Birth:	Health Care Number:	Expire Date:
Allergies:		

Language of Preference:

Are you of Indigenous Origin? ◯ Yes ◯ No

Please Specify:

Next of Kin: Relationship:

Address:
Telephone:

Referral Source:
Agency:
Telephone:
Email Address:
Mailing Address:

Does the client have a living arrangement/residence to return to? ◯ No ◯ Yes

If different from above please provide the address:

Post-Discharge Care Provider

Name:	
Agency:	
Address:	
City/Town:	Postal Code:
Email Address:	
Telephone:	

Name and Professional Designation: _____ Date: _____

Signature: _____

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Adult Addictions Inpatient Treatment

REFERRAL ASSESSMENT (Part III)

Please check boxes for areas the client is seeking treatment

Substance Use Treatment	◯ Yes	◯ No
Problem Gambling Treatment	◯ Yes	◯ No
Both Substance Use & Problem Gambling Treatment	◯ Yes	◯ No
Does the client use cannabis?	◯ Yes	◯ No
Is abstinence from all substances the client's goal	◯ Yes	◯ No

Previous Addictions Treatment (check all that apply):

☐ Outpatient Counselling	Date: _____	☐ Completed	☐ Ongoing
☐ Humberwood	Date: _____	☐ Completed	☐ Incomplete
☐ Grace Center	Date: _____	☐ Completed	☐ Incomplete
☐ Other	Date: _____	☐ Completed	☐ Incomplete

Substance Use/Gambling History

Primary Substance Used	Method of Use	Years of Use	Amount used Daily	Date of Last Use

Secondary Substance Used	Method of Use	Years of Use	Amount used Daily	Date of Last Use

Additional Substance	Method of Use	Years of Use	Amount used Daily	Date of Last Use

Type of Gambling	Duration of Gambling	Frequency	Last Date of Gambling	SOGS Score

Name and Professional Designation: _____ Date: _____

Signature: _____

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Adult Addictions Inpatient Treatment

REFERRAL ASSESSMENT (Part IV)

Group Ready

Is the client able to participate in a group based program	☐ Yes	☐ No
Is the client willing to participate in group therapy	☐ Yes	☐ No
Has the client ever attended a self-help meeting	☐ Yes	☐ No
Is the client subject to a Community Treatment Order (CTO)	☐ Yes	☐ No

Psychological/Mental Health (check all that apply)

Current	Last 6 months	6 months or longer		Current	Last 6 months	6 months or longer	
☐	☐	☐	Acute or Chronic Psychosis (Thoughts disorder/ hallucination/delusion)	☐	☐	☐	Dissociative Disorder
☐	☐	☐	Substance Use (Drug / and or alcohol)	☐	☐	☐	Eating Disorder
☐	☐	☐	ADHD/ADD	☐	☐	☐	PTSD, Abuse, Trauma or OSIs (Occupational Stress Injuries (OSI)
☐	☐	☐	Anxiety Disorder (social Phobia or panic disorder)	☐	☐	☐	Major Depression (Unipolar)
☐	☐	☐	Autism or Autism Spectrum Disorder	☐	☐	☐	OCD (Obsessive Compulsive Disorder)
☐	☐	☐	Bipolar Disorder (Hypomania, mania, depression)	☐	☐	☐	Personality Disorder
☐	☐	☐	Chronic Pain	☐	☐	☐	Schizophrenia
☐	☐	☐	Cognitive Disorder (Head injury, memory problem)	☐	☐	☐	Dementia

Comments:

Has the client been treated by a psychiatrist? ☐ Yes ☐ No

If yes please provide name of psychiatrist and date of last appointment:

Name: _____

Date: _____

Name and Professional Designation: _____ Date: _____

Signature: _____

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REFERRAL ASSESSMENT (Part V)

Current Safety Risks (Check all that apply)

☐ Current active suicidal thoughts	☐ History of fire setting
☐ Current legal issues	☐ History of suicide attempts Date of last attempt: _____
☐ Current passive suicidal thoughts	☐ History of violence towards self (self-harm)
☐ Current thoughts of harm to others	☐ History of violence towards others or property
☐ Dissociation	☐ Risk of falling, history of recent falls
☐ Flashbacks	☐ Wandering/AWOL risk

Please provide additional details regarding risks identified above:

Marital Status

☐ Married ☐ Common Law ☐ Single ☐ Separated/Divorced

Has the client's relationship with a significant other been impacted by their addictions? ☐ Yes ☐ No

Check all that apply

☐ Separation/Divorce ☐ Violence ☐ Financial Stressors

Comments

Does the client's partner also have a substance use or gambling problem? ☐ Yes ☐ No

Family

Has the client's family of origin been impacted by their addiction? ☐ Yes ☐ No

Check all that apply

☐ Parents ☐ Siblings ☐ Children ☐ Extended family

Comments:

Is there a history of substance use/gambling problem in the client's family? ☐ Yes ☐ No

Comments:

Name and Professional Designation: _____ Date: _____

Signature: _____

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REFERRAL ASSESSMENT (Part VI)

Social/Leisure

Has the client's addiction affected any of the following areas?

- ☐ Peer Groups/Friends
- ☐ Isolation/withdrawal from social activities
- ☐ Limited socialization outside of their addiction

Comments

Education Level

☐ Elementary (grade 8 or less) ☐ Post-Secondary ☐ High school ☐ Unknown

Employment

☐ Full time ☐ Part time ☐ Self employed ☐ Retired

☐ Social Assistance ☐ Employment Insurance ☐ Disability Assistance ☐ Unemployed

If the client is not working, when were they last employed? _____

Impact of substance use/gambling problem on employment

Legal History

☐ Past criminal charges

☐ Probation:

Name of probation officer: _____ End date of order _____

☐ House arrest

Upcoming court date

☐ Seeking treatment because of a court order

Specific Needs check all that apply):

☐ Difficulty reading/writing ☐ Hard of hearing

☐ Visual impairment ☐ Physical disability ☐ Intellectual disability

☐ Cognitive/memory problems ☐ Speech impairment ☐ Language barriers

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REFERRAL ASSESSMENT (Part VII)

Would an accommodation be required for a client to participate in education sessions and complete assignments? ☐ Yes ☐ No

Comments

Clinician's Assessment:

(Assessment of readiness, include information on motivations, stage of change, client's strengths, summary of screening tools, previous treatments, and client's treatment goals)

Stage of Change Assessment:
Please check which is most applicable to the client at the time of this assessment

- ☐ Pre contemplation
- ☐ Contemplation
- ☐ Preparation
- ☐ Action
- ☐ Maintenance
- ☐ Relapse

Name and Professional Designation: _____ Date: _____

Signature: _____

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Adult Addictions Inpatient Treatment

REFERRAL ASSESSMENT (Part VIII)

Client Agreement

The below must be read and signed prior to your referral being sent. If you have any questions about the agreements, please discuss with your counsellor.

1) I will not use alcohol or drugs (except medication prescribed by a doctor or nurse practitioner), or participate in gambling activities while I am in treatment. I understand that failure to do this may result in discharge from the treatment program.
2) I will work to the best of my ability to build a new lifestyle free from my addiction.
3) I will work within the structure of this program, as outlined, and attend the various activities (lectures, films, meetings) at the scheduled time. I understand that it is my responsibility to be present and on time for all scheduled activities. Failure to do this may result in discharge from the treatment program.
4) I will attend all meetings of Alcoholics Anonymous, Narcotics Anonymous, or other self-help groups that are part of the treatment program.
5) I agree that I have a responsibility to my group members and myself and that the situations that are described in group remain in group to protect the trust that group members have for one another.
6) I will not borrow money from other residents while involved in the treatment program. I will not lend money to other residents.
7) I will complete all assignments and hand them in at the designated time.
8) I understand that any kind of violence will not be tolerated. Any threatening, abusive, or hostile behavior will result in immediate action. It could lead to discharge, criminal charges, and, where applicable, invoice for property damage.
9) I will not form an exclusive or sexual relationship with any person while I am involved in treatment. I understand that such behavior will result in immediate discharge.
10) I understand that at any time, I may be asked by staff to submit to a random urine test for the purpose of an alcohol/ drug screening. I understand that refusal to take such a test is grounds for discharge from treatment.
11) I understand that my personal belongings, including my vehicle, will be searched upon admission to, and discharge from, the Centre and may be searched at any point during the program. This is to ensure that the property remains free from addictive substances. I further understand that I will be informed of and present for any such searches. Refusal to consent to such searches will result in discharge.
12) I understand that regular nightly room checks will be conducted by staff during my stay. I agree to wear night attire when going to bed.
13) I understand that I will not be permitted to smoke or vape on the Centre's property, in keeping with the organization's Smoke Free Policy.
14) I understand that I will not be permitted to wear any scented products while at the Centre.
15) I will dress appropriately at all times. I will not wear T-shirts that may be an indication of my addiction. I will not wear clothing with sexual comments, foul language etc., which may be offensive to others. I understand that proper footwear will be worn at all times.
16) I understand that at any time, health care professionals may be observing the work being done with clients at the treatment center. I understand that I will be informed in advance of the presence and I Identity of the observer and that this person will be bound by rules of confidentiality. This observation may include social/health care and addictions staff and students, sitting in on individual or group sessions or by using a one-way observation mirror and/or audio equipment. The purpose of this observation is to provide staff supervision and training, and to ensure we provide the best possible service to clients.

Name and Professional Designation: _____ Date: _____

Signature: _____

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Adult Addictions Inpatient Treatment

REFERRAL ASSESSMENT (Part VIII)

- ☐ I have read the above expectations, understand their meaning and agree to follow them
- ☐ I understand that failure to follow these expectations and the rules and regulations that have been explained to me mean that I may be discharged from treatment
- ☐ I have reviewed this referral and medical assessment and agree for this referral to be made on my behalf
- ☐ I consent for Mental Health and Addictions Community Services to follow up regarding this referral to assist with preparation for residential treatment

Signature of client _____ Date _____

Signature of Referral Source _____ Date _____

Please email complete referral package to: inptaddref@westernhealth.nl.ca

Name and Professional Designation: _____ Date: _____

Signature: _____

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