Addiction Recovery Program at CCL

ARP Referral Information Form

This form is to be completed by the *Referrer*, and then faxed to the attention of "Intake" at 604 681 5546.

Client Personal Details

Name: ____

Address: ____ DOB: ___ / ___ / _________

____

Phone: _____________________ Cel: _____________________________

Referring Agent

Name: ____ Phone: ________________

Agency: ____

Position: ____

Other Professionals Involved (eg Social Worker, A&D Counsellor, Mental Health Worker, Probation Officer)

Name: ____ Phone: ________________

Agency: ____

Position: ____

Legal Information

Current Charges: ____

Outstanding Warrants: ____

Previous Convictions: ____

Financial Information

Current source of income: ___________________________ (eg Income Assistance, Pension, Employment Insurance)

Form of funding if accepted to ARP (please tick one box):

☐ Income assistance from Ministry of Housing & Social Development – Worker: __________________

☐ Accommodation Fee Subsidy Office: ___________________

☐ Employment Insurance

☐ Self Pay

☐ Other

Alcohol and Drug History

Presenting Problem: ____

Client's Goals: ____

____

Current Treatment/Supports: ____

____

____

Previous Treatment/Supports: ____

____

____

____

____

Is the client currently on a Methadone Program? Yes / No

Is the client currently prescribed benzodiazepines? Yes / No

Please complete the attached Substance Use History Form

Medical History

Name of Doctor(s): ___________________________ Phone: _____________

Current Medical Conditions: ____

____

____

Current Medications: ____

____

Allergies: ____

Current & previous contact with Mental Health Services (circle as appropriate):

Psychiatrist Psychologist Counsellor Psychiatric Unit

Provide Details: ____

____

Thoughts of self-harm: Yes / No (circle as appropriate) Most recent: _________________________

Thoughts of suicide: Yes / No (circle as appropriate) Most recent: _________________________

Previous suicide attempt(s): Yes / No (circle as appropriate)Details: _____________________________

____

BC Medical: Yes / No

Supported Recovery Goals

What does the client hope to receive from supported recovery? ____

____

____

What is the client's attitude toward supported recover? ____

____

____

Has the client had previous contact with the Addiction Recovery Program at CCL? Yes / No

Completed by: ____(Name of referrer)

Position: ____

Agency: ____

Date: ____

Thank you for completing all sections. Please fax to the attention of "Intake" at 604 681 5546.

Addiction Recovery Program at CCL
Substance Use History

Substance	First Use (age)	Last Use	Method (1-6)[1]	Frequency (past 6 months)	Quantity (past 6 months)
Alcohol					
Cannabis Marijuana, Hashish, Oil					
Opioids Heroin, Methadone, Morphine, Codeine					
Cocaine Powder Crack cocaine					
Amphetamines Methamphetamine, liquid meth, amphetamines					
Hallucinogens LSD, mushrooms, ecstasy					
Inhalants Glue, gas, point thinner, sprays					
Sedatives, hypnotics or anxiolytics Benzodiazepines, GHB, ketamine					
Caffeine Coffee, tea, cola, chocolate					
Nicotine Cigarettes, tobacco					
Prescription Medication Benzodiazepines, Opiate based, other					
Other					

[1] **1 = Ingest 2 = Smoke 3 = Inject 4 = Snort 5 = Inhale 6 = Other**