The Salvation Army Homestead

975 West 57th Avenue
Vancouver BC V6P 1S4
www.vancouverhomestead.ca

Telephone: (604) 266-9696
Fax: (604) 266-7401
Email:homesteadintake@yahoo.ca

Enclosed is the Salvation Army Homestead's referral package for its twenty four bed residential recovery program for women. The minimum commitment to the program is one month and the total length of the program is eighteen weeks.

Once the women have completed the initial phase of the supportive recovery program they have the option of transitioning to our eight bed second stage housing called Independent Living where they can reside in a supportive environment for up to a year.
Criteria for Admission to the program are women 19 and older who are struggling with drug and or alcohol abuse. We are fully wheelchair accessible however the woman needs to be physically able to fully participate in the program.

A referral to the Homestead can be made by a professional (for example: a Doctor, Counselor or Social Worker) or a woman can self refer. In order to secure a bed at the Homestead, the candidate must have **funding arranged** for her stay; have a **physician complete the pre-admission medical form** and **pre-admission prescription form**. The candidate also needs to complete **TB test**. We accept women on Methadone up to 100ml that have been stable for one month on one dose.

Please call if you have any questions. Thank you for your interest.

Regards,

Katherine Walker

Katherine Walker
Intake Worker
Support Recovery

CLIENT REFERRAL FORM FOR
REFERRAL TO SUPPORT RECOVERY FACILITIES

Facilities wishing to refer clients to support recovery facilities are requested to complete this Client Referral Form. Please provide as much detail as possible. Completed referral forms can be faxed to individual support recovery facilities.

REFERRAL	
Client's Surname:	First Name:
Address:	Tel #: Messages:
PHN: SIN:	DOB: (yy/mm/dd)
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Complete ☐ Partial	Dependant Children: ☐ No ☐ Yes # of Children _____ Details of Care: _____ _____
Funding Source: ☐ MHR ☐ EAP ☐ Self-Paying ☐ Other:_____	
REFERRING AGENCY: _____	REFERRING STAFF: _____ Phone #: _____

CONTACT INFORMATION	
Probation / Parole Officer: Court Date Pending: ☐ Yes ☐ No ☐ Unknown	Phone #:
Drug and Alcohol Counselor:	Phone #:
GP / Psychiatrist:	Phone #:
Mental Health Team:	Phone #:
MHR / MCF / Contact Person	Phone #:

SUBSTANCE USE HISTORY						
Drug/Alcohol chart	Check if Used	Age First Used	Duration	Frequency	Amount	Last Used
Alcohol Products						
Marijuana/Hashish/Hash Oil						
Cocaine						
Benzodiazepines						
Speed/Whites						
Codeine						
Heroin						
Percodan/Morphine						
LSD/Mescaline/MDA						
Mushrooms/Psilocybin						
Glue/Solvent/Paint/Gas						
Talwin/Ritalin						
Methadone						
Barbiturates						
Tobacco						
Caffeine						
Prescription Drugs						
Over the Counter Drugs						
Other						

How long has the client been in your facility? _____

Is the client on a methadone maintenance program? No / Yes for How Long?_____

Support Groups:

☐ AA ☐ NA ☐ CA ☐ COA ☐ ACOA ☐ OTHER: _____

Area of Concern for Client:

☐ Dependency	☐ Co-Dependency	☐ ACOA/COA
☐ Violence	☐ Medical	☐ Sexual Abuse
☐ Pregnancy	☐ Detoxification	☐ Couple/Family
☐ Other: _____		

PHYSICAL HEALTH

☐ **HIV** ☐ **TB** ☐ **HEP C** ☐ **Diabetes** ☐ **Epileptic**

Physical Disability: ☐ No ☐ Yes If Yes, describe: _____

Other Health Issues: _____

Date of most recent physical examination, if known: _____

Previous / Current Treatments or Hospitalizations:

Admission Date:	Discharge Date:	Detox / Treatment Program / Hospital	Reason
_____	_____	_____	_____
_____	_____	_____	_____

RELEVANT MENTAL HEALTH HISTORY

Psychiatric Diagnosis:

_____

_____

_____

_____

History of Violence/Abuse (of self) If yes, describe

Physical: ☐ Yes ☐ No ☐ N/K

Sexual: ☐ Yes ☐ No ☐ N/K

Other: ☐ Yes ☐ No ☐ N/K

History of Violence/Abuse (of others) If yes, describe

Physical: ☐ Yes ☐ No ☐ N/K

Sexual: ☐ Yes ☐ No ☐ N/K

Other: ☐ Yes ☐ No ☐ N/K

Medications: _____

_____

_____

Compliant with Medications: Yes ☐ ☐ No

History of Suicide Attempts / Self-Harming? Yes ☐ ☐ No

GENERAL INFORMATION

Client Profile Summary:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: _____ Date: _____

THIS FORM MUST BE ACCOMPANIED BY AN AUTHORIZATION FORM FROM THE CLIENT PERMITTING THE REFERRING AGENCY TO RELEASE FURTHER INFORMATION TO THE FACILITY

The Salvation Army Homestead

975 West 57th Avenue
Vancouver BC V6P 1S4
www.vancouverhomestead.ca

Telephone: (604) 266-9696
Fax: (604) 266-7401
Email:homesteadintake@yahoo.ca

Client Name: _____

Social Insurance Number: _____

The above client has met with her Financial Aid Worker and has received approval to enter the Residential Addiction Program at Homestead.

The per diem cost (user fee of $40.00) will be paid through the Ministry of Human Resources Mountain View Office *

The client's home office will be responsible for the following:

1. Recording electronically on the client's file that the client is approved to enter the Addiction Program at Homestead;
2. Providing monthly comfort allowance to the client, to be mailed to the client at Homestead's address

If you have any questions, please contact either the Intake Worker at Homestead or the Liaison Worker at Mountain View Office.
Please fax this form to Homestead only when it has been signed or stamped by MEIA worker.

Name of client's Financial Aid Worker: _____
(Please print)

Approval given by (if different than above): _____
(Please print)

Address: _____
_____
_____

Phone: _____

Signature: _____ Date: _____

*** Amount set by Ministry for Children and Families, and agreed upon by Ministry of Human Resources. Effective 1 June 1999**

RELEASE OF INFORMATION

I_____ understand that all information gathered by The Salvation Army Homestead staff is considered confidential and will only be shared with those persons or agencies that I have given permission to share information with.
I am aware that in some situations information about me may be disclosed because it is required or justified by law or by licensing requirements. (For example: persons aware of child abuse, or intent to harm your own or another's life are required to be reported to the appropriate professionals).

I hereby authorize the following agencies/people to be contacted for the purpose of assisting in my care.

Client Initials

Ministry of Human Resources_____ _____

F.A.W. _____ _____

Social Worker _____ _____

Health Professionals (list names)

Safeway Pharmacy _____ _____

Homestead Referring Physician _____ _____

Public Health Nurse _____ _____

Mental Health/Psychiatrist _____ _____

Alcohol & Drug Programs_____ _____

Counsellor_____ _____

South Addictions_____ _____ _____

National Native Alcohol & Drug Program _____ _____

Health & Welfare Canada (MSP Branch) _____ _____

Probation Officer and Lawyer _____ _____

Other (list name/relationship)

_____ _____

_____ _____

_____ _____

_____ _____ _____

Staff Signature Client Signature Date

*****NOTE*****

This authorization shall expire two years after date of signature.

At any time prior to the expiry date, you may revoke this authorization by making a request in writing to The Salvation Army Homestead. Any such revocation would become effective upon receipt at The Salvation Army Homestead and relate only to information requested after that date

PRE-ADMISSION MEDICAL FORM

Name: _____

Address : _____

Date of Birth: _____

PHN: _____

Physician (please print)

Name: _____

Phone: _____

The above-named has applied for admission to The Salvation Army Homestead's Supportive Recovery Program. The following medical information would be appreciated to ensure adequate medical care during her program.

1. Approximate length of time that you have treated this patient:_____

2. To your knowledge, is the client seeking treatment from any other physician:

   ☐ No ☐ Yes If yes, please identify who: _____

3. Please indicate whether this patient suffers from any medical condition related to the following at the present time:

☐ Heart	☐ Lung	☐ G.I.
☐ Urinary/Bladder	☐ Skin	☐ Circulation
☐ Neurological	☐ Reproductive	☐ Eating Disorder
☐ Anxiety	☐ Depression	☐ T.B.
☐ Hepatitis	☐ S.T.D.	☐ Mental Health

☐ Other: _____

4. Do any of these conditions restrict the patients' activity in any way?

   ☐ No ☐ Yes If yes, the restriction is: _____

   Is this patient physically fit to participate in aerobic exercise? No ☐ Yes ☐

5. Please list any medication that this patient requires. **(Medications that could lead to physical dependency, for example Benzodiazepines and Barbiturates, will need to be approved on a case by case bases. Any changes in the following orders will need to be made in writing to the Homestead.)**

   _____ _____ _____

6. As per provincial licensing requirements, has this patient been tested for T.B. Yes ☐ No ☐

   (Please proved a copy of T.B Results)

   Physician's Signature: _____

   Address: _____

   Date: _____

7. Do you advice this person to eat or not eat a specific food? (If yes please state why.)

   _____

   _____

Patient's name: _____

Date of Birth: _____

Care Card #: _____

Doctor's name: _____

Your patient is applying to The Salvation Army Homestead Support Recovery Program for substance abuse concerns. Only medication appropriate to a woman in recovery from substance abuse is permitted.

In accordance with Community Care Licensing, all medications dispensed by staff at Homestead are ordered through Safeway Pharmacy. Any prescriptions, or changes to existing orders, should be phoned in to Safeway Pharmacy (Phone# 604 733-9342 X4).

As part of the intake process we require women to come to the Homestead with **unfilled prescriptions** for the medications they are currently on so Safeway Pharmacy can dispense each woman's medication using the bubble pack system.

It is our priority at the Homestead to support your patient in caring for her physical and mental health. **Please list below ALL prescriptions and special instructions that will be accompanying your patient to her intake at the Homestead**. (E.g. prescriptions; orders for over-the-counter medication; equipment such as vaporizers, heating pads, etc; dietary restrictions; danger signs to be aware of).

Without your written instructions we are unable to permit your patient to take prescription medications, over the counter medications, vitamins/minerals, or to engage in medical procedures.

Please **mark off** which over the counter medications your patient has permission to take:

☐ ***Acetaminophen*** *(Tylenol) 500 mg tablets: 2 tablets four times a day as required. Not to exceed 8 tablets within a 24 hour period.*

☐ ***Ibuprofen*** *(Advil) 200 mg tablets: 1-2 tablets three times a day as required. Not to exceed 6 tablets a day within a 24 hour period.*

☐ ***Gravol Natural Source – Ginger*** *500 mg: 2 tablets three times a day as required. Not to exceed 6 tablets within a 24 hour period.*

☐ ***Lanacane*** *30gm: apply 3-4 times daily, as needed.*

☐ ***Loperamide:-*** *2 caplets initially followed by 1 caplet after each lose bowel movement. Max 8 caplets a day.*

☐ ***Cetirizine*** *HCL 10mg: ½ -1 tablet every 24 hours*

☐ ***Cepacol*** **Lozenges:** ***take one every two hours as needed***

☐ ***Antacids:*** *Chew 2 to 4 tablets as required. Not to exceed 8 tablets in a 24 hour period*

☐ ***Metamucil:*** *1 tablespoon 1-3 times within a 24 hour period in an 8 ounce glass of water.*

If your patient needs any of the following please specify dosage:

☐ ***Vitamin B*** _____

☐ ***Vitamin D*** _____

☐ ***Folic Acid*** _____

☐ ***Multivitamins*** _____

☐ ***Vitamin C*** _____

☐ ***Calcium*** _____

☐ ***Prenatal*** _____

☐ ***Omega 3 or 369*** _____

If there are any Vitamins or Minerals that are not listed please provided specific medical reasons for your patients to need to take this medication and information about dosage on the next page.
Due to our licensing policies if the above are **not indicated we will be unable to let your patient take these medications**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor's signature: _____Date:_____

Thank you for your cooperation. If you have any questions, please call: Our intake worker, Katherine at 604-266-3433.

I_____ consent to _____
(Name of client) (Name of medical doctor)
releasing the information requested above.

_____ _____ _____
Signature Witness Date

The Salvation Army Homestead
Methadone Maintenance Program (MMP) – Patient Information

(This is to be completed by the woman's methadone Doctor prior to her admission).

Patient Name: _____ Date of Birth: _____
PHN: _____

Length of time in MMP: _____ Current Dose of Methadone: _____ Length of time on this dose: _____
Opiate history: _____
_____
_____

History of Carries: **YES** **NO** If yes, how frequently? _____
_____
_____

Latest urine test result: _____ Date: _____
Latest liver enzymes test result: _____ Date: _____

Other substances of abuse or dependence: _____
_____
_____
_____
_____

Last CPx: _____ by: _____ Result: _____
(date) (physician)
If abnormal, details: _____
_____
_____

Related illnesses: (ie: HIV+, AIDS, Hep C, Hep B, other) _____
_____
_____
_____

Is the woman pregnant? **YES** **NO** If so, how far along in the pregnancy is she? _____
_____

Any other information you feel we need to know? _____
_____
_____

Community MMP Physician's Name: _____
Signature: _____

CPSID# _____ Fax # _____ Date: _____