BENBOWOPKA TREATMENT CENTRE

REFERRAL FORM

Referral Agency:	Referent:
Client Last Name:	Client First Name:
Nick Name:	Client Gender: F ☐ M ☐
Date of Birth: _____/_____/_____ Age: (dd) (mm) (year) Place of Birth:	Language Spoken:
Mother's Maiden Name:	Last four digits of S.I.N. :
Telephone Number:	Health Card Number: Expiry Date:
First Nation:	Status Number:
Residing on First Nation: Y ☐ N ☐ How Long:	Other First Nation Residing On:
Client Full Address: **Please include Postal Code**	
Emergency Contact:	Relationship of Emergency Contact:
Telephone Number:	Cellular Number:
Family Physician:	Telephone Number:

Marital Status				**Living Arrangements**			
Single:	☐	Single Parent:	☐	With Parents:	☐	With Children:	☐
Married:	☐	Common-Law:	☐	With Spouse:	☐	With Spouse & Children:	☐
Separated:	☐	Divorced:	☐	With Relatives:	☐	With Friends:	☐
Alone:	☐	Widow/Widower:	☐	Alone:	☐	Other Arrangements:	☐
Date of Separation/Divorce:							
Accommodations Following Treatment:							

Clients Family History

Who were you raised by? Parents ❒ Grandparents ❒ Extended Family ❒ Foster Parents ❒ Adoptive Family ❒

Who was your primary care giver? _____

Please describe your parents parenting style: _____

How many siblings do you have? _____

Did your parents or any other family member attend a residential school? Yes ❒ No ❒

Who? _____

Client's Dependent Children/Adult Children/Wards		
Gender	**Age**	**Name of Guardian During Treatment**

Is a Children's Aid Society or any other Family Service Agency currently involved with your family?

Y ☐ N ☐ Name of Agency:

Scheduled Visiting Arrangements:

Has C.A.S. or any other Family Service Agency been involved with your family? If so, when:

Additional Information

List hobbies, interests, strengths, accomplishments or knowledge the client is proud of:

Client Education	
Elementary Level:	Elementary School:
Secondary Level:	Secondary School:
College:	Course:
Course Completed: Y ☐ N ☐ If no, how many semesters were completed?	
University:	Concentration of Study:
Course Completed: Y ☐ N ☐ If no, how many semesters were completed?	
Trade/Technical Program:	Trade School:
Course Completed: Y ☐ N ☐ If no, how much of course was completed?	

Employment	
Permanent ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Temporary ☐ Homemaker ☐ **Apprenticeship ☐ Student ☐ Retired ☐ Unemployed ☐**	
Current Employer:	Usual Occupation:
Length of Employment:	Last Date of Employment:
Will you be returning to current place of employment?	
Employment plans following treatment:	
Client's Source of Income	
Employment ☐ Employment Insurance ☐ Ontario Works ☐ Pension ☐ Savings ☐ No Income ☐ Other ☐ _____	

Mental Health/Psychiatric History (Please Complete If Applicable)

In-Patient	
Name of Facility:	Date Admitted:
Presenting Problem:	Type of Treatment:
Duration of Stay:	Treatment Completed: Y ❒ N ❒
Has the client ever been hospitalized for mental health issues? Y ❒ N ❒ If yes, please note details: _____ _____ (Facility Name) (Date)	
Has the client experienced suicidal ideations or attempted suicide? Y ❒ N ❒ If yes, please note when: _____	
Does the client have a history of Psychiatric conditions? Y ❒ N ❒ If yes, provide diagnosis: _____ Was a Psychological/Psychiatric Evaluation completed: Y ❒ N ❒ **If yes, please include Psychological/Psychiatric Evaluation and a signed consent authorizing the release of the Evaluation to Benbowopka Treatment Centre.**	

Past Mental Health/Psychiatric (Please Complete If Applicable)

In-Patient	
Name of Facility:	Date Admitted:
Presenting Problem:	Type of Treatment:
Duration of Stay:	Treatment Completed: Y ❒ N ❒

In-Patient	
Name of Facility:	Date Admitted:
Presenting Problem:	Type of Treatment:
Duration of Stay:	Treatment Completed: Y ❒ N ❒

Previous Alcohol and Substance Treatment Programs Attended (List Most Recent First)

Name of Facility:	Date Entered:
Program Duration:	Type of Treatment:
Length of Stay:	Presenting Problem:
Was treatment completed: Y ☐ N ☐ If no, explain reason for leaving the treatment program: _____ Duration of abstinence following the treatment program: _____	

Name of Facility:	Date Entered:
Program Duration:	Type of Treatment:
Length of Stay:	Presenting Problem:
Was treatment completed: Y ☐ N ☐ If no, explain reason for leaving the treatment program: _____ Duration of abstinence following the treatment program: _____	

Additional Information of Past Treatment Programs Attended:

Presenting problem(s) for which client now seeks treatment:
Identify any issues or concerns client may have regarding treatment at Benbowopka Treatment Centre:

Alcohol and Substance Use

Identify kind of substance(s) you have used: Please complete all sections

Substance	Age First Used	Frequency of Use	Amount of Used	Date Last Used

Legal Status

Criminal Court System:

Pending Charges: Y ☐ N ☐ List Charge(s) _____

_____

_____

Probation/Parole: Y ☐ N ☐ Date: _____

Provide a copy of Probation Order

Scheduled Court Appearance: Date: _____

Family Court System:

Are you involved with Ontario Family Court? Y ☐ N ☐

Upcoming Ontario Family Court Date: _____

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Aftercare Planning

To assist clients in their Aftercare Plan upon completion of the treatment program

Client Name: _____ **Referent:** _____

Has an Aftercare Plan or Follow-Up Plan been made with the client and you, the Referent? Y ☐ N ☐

Please indicate a date for client's first session with you following his/her completion of the treatment program:
_____

What type of aftercare services will benefit your client:

_____

_____

_____

What programs are available in your community or organization to assist clients in their recovery?

1. _____
2. _____
3. _____
4. _____
5. _____

Do you feel working together in developing an Aftercare Plan will benefit your client? Y ☐ N ☐

_____

_____

_____

_____

Referent Signature: _____ **Date:** _____

Telephone Number: _____ **Ext:** _____

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MEDICAL RELEASE INFORMATION

CLIENTS RESPONSIBILITIES: Please have all information completed by a Physician/Nurse Practitioner and return the completed form to Benbowopka Treatment Centre. Clients will not receive a treatment date confirmation without a completed Medical. **PLEASE NOTE: Benbowopka Treatment Centre will not be responsible for any cost with having this Medical Release Information completed. Thank you.**

Physician/Nurse Practitioner: Please Print	**Telephone Number:**
Client Surname:	**First Name:**
Date of Birth:	**Gender: M ❒ F ❒**
Telephone Number:	**Marital Status:**
Health Card Number:	
Client Address:	

Physical Health and Condition:

Please Note Any Future Medical Treatments Client May Require:

Does the client have a disability or mobility condition? Y ❒ N ❒ **If yes, please describe: _____**	
List Allergies: **Is an Epipen Required: Y ❒ N ❒**	**Special Diet Required? Y ❒ N ❒** **Type:**
Received Influenza Vaccine: Y ❒ N ❒	**Received Pneumococcal Vaccine: Y ❒ N ❒**

Psychological Condition: (History and Treatment)

PRESCRIBED MEDICATION

Medication and Dosage PLEASE HAVE MEDICATON BLISTER PACKED	Start and End Date of Medication	Psychoactive Effect (Yes/No)	Corresponding Diagnosis

Physician/Nurse Practitioner Signature:	**Date:**

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CIRCLE OF CARE: CONSENT TO THE RELEASE OF INFORMATION AND PLANNING FOR AFTERCARE SERVICES FORM

I _____, give permission for the mutual exchange of
(*Print Name*)
information between the Benbowopka Treatment Centre and:

❒ Psychiatrist: _____ ❒ Physician: _____

❒ Hospital/Health Staff (Specify): _____

❒ Probation: _____❒ Lawyer: _____

❒ NNADAP/Referral Worker: _____

❒ Medical Transportation Services: _____

❒ Other Treatment Centres/Withdrawal Management Services: _____

_____

❒ Family/Significant Others (Specify): _____

❒ Other (Specify): _____

_____

In respect of _____, _____
(Print Name) *(Date of Birth)*

as it relates to the provision of care/service while at the Benbowopka Treatment Centre and planning for discharge/aftercare services for the individual named herein. This consent shall remain in effect from this date until the purpose for which the information was disclosed has been achieved and/or I am no longer

involved in this service. It is understood that I can revoke this agreement at any time either verbally or in writing. I have read, understand and agree to the terms and conditions outlined on the reverse side of this release.

_____

(Signature)

_____

(Witness/Staff Signature)

Dated this _____ day of _____, 20_____.

Consent Withdrawn: Date: _____, 20_____.

_____ _____

(Signature) *(Witness/Staff Signature)*

CIRCLE OF CARE: TERMS AND CONDITIONS FOR THE RELEASE OF INFORMATION AND PLANNING FOR AFTERCARE SERVICES

1. The Benbowopka Treatment Centre provides service through a team approach. From time to time this means client specific information must be shared with fellow employees of the Benbowopka Treatment Centre and with other significant supports involved in the care and/or treatment of the client.

2. Confidentiality shall be maintained by employees of the Benbowopka Treatment Centre except where there is imminent risk of harm to self or others or when subpoenaed by the court.

3. All other release/review of client information by employees of the Benbowopka Treatment Centre shall only be carried out with the expressed consent of the individual as outlined in the Circle of Care: Consent to Release of Information and Planning for Aftercare Services Form signed by the client.

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