Standardized Referral Package for Residential Services

Addictions Ontario residential service providers have adopted a **standardized referral package** for making referrals to its Residential Treatment programs or Residential Supportive Treatment Services-Level 1 facilities. It **replaces existing referral forms** in Addictions Ontario member organizations. This package contains all the information needed to make informed decisions about admissions to programs and, we are pleased to advise, that with the exception of one very brief form, it consists of documents already completed/information already obtained by the referring agency. Referral agents are requested to forward the following documents upon referral:

1. **Client Information and Admission Information screens from Catalyst**. Print out (electronic transfer pending) these screens and please ensure to check the "Expand All" box at the top of each screen to provide complete information.

   Or

   Standardized Residential Services Referral Form (2 pages). Complete and send this form **only** if you do not have access to/or cannot send the required Catalyst screens. This form obtains the same information needed for completion of Catalyst screens. (See note.)

2. **Supplemental Referral Information Form** (1 pg.**)**. Provides information needed by residential facilities that is not collected in Catalyst or the standardized form. (See note.)

3. **GAIN- Q3 Recommendation and Referral Summary (Q3RRS)**

   Or

   Admission/Discharge Tracking Summary and the **Drug History Questionnaire** and the **Health Screening** form. If the client is using prescribed medication, please ensure that section on the Health Screening form is accurate, current, and complete.

4. Please ensure to include clients **health card number** and any referrals to other **treatment programs.**

Note: Margins sometimes jump about in electronic transfers, so may need adjustment. Also, you may get a message when printing that the margins are outside the printable area. Ignore it and click "yes."

Standardized Residential Services Referral Form*

*(In lieu of Catalyst Client Information and Admission Information screens)

Client # _____ (Res. facility use only) Referral Date: d_____/m_____/y_____ (Res. facility use only)

Client Name: _____ , _____DOB:____/____/____ Age: ____
Last First

Street Address: _____ City: _____

Postal Code (if NFA, list a P.C. for current county): _____ County: _____

Home Phone: ( ) _____ □ phone call allowed □ message allowed

Alt. Number: ( ) _____ □ phone call allowed □ message allowed

Emergency Contact: _____ Phone # ( ) _____

Health Card # _____

Referral Information

Referral Date: d____/m____/y____ Type of Service: ☐ Comm. Tx. &/or A/R Services or ☐ WMS/Detox

Referral Agency: _____ Contact Name: _____

Phone Number: ( ) _____ Ext: _____ Fax Number: ( ) _____

Treatment Mandated/Required by: _____ Legal Status: _____

Pending Legal Charges: ☐No ☐Yes, _____ Court Date: _____

Relationship Status: _____ Employment Status: _____

Level of Education: _____ Source of Income: _____

Presenting Issues at Admission: ☐ Alcohol ☐ Drugs _____ ☐ Gambling

Presenting Problem Substances

	Substance	Frequency Used in Past 30 Days
1st	_____	_____
2nd	_____	_____
3rd	_____	_____

Substances Used in the Past 12 Months:_____

_____

Problem Gambling Identified: Y N Gambling activities engaged in the past 12 months: _____

_____

Health Status/Problems: Check all that apply

☐ Vision ☐ Hearing ☐ Mobility ☐ Non-medical IV drug use, if yes last use: _____

☐ Number of overnight hospitalizations in the past 12 months for physical health problems: _____

Reason(s) for hospitalization: _____

Diagnosed with a mental health problem by a qualified mental health professional? ☐ No ☐ Yes,

☐ Within the last 12 months ☐ Within a lifetime

Most recent diagnosis # 1: _____

Most recent diagnosis # 2: _____

Hospitalized for a mental health problem? ☐ No ☐ Yes,

☐ Within the last 12 months ☐ Within a lifetime

Received treatment for a mental health, emotional, behavioral, or psychological problem from community mental health program/professional? ☐ No ☐ Yes,

☐ Currently ☐ Within the last 12 months ☐ Within a lifetime

Name of service provider: _____

Contact information: _____

Prescribed medication for a mental health problem: ☐ No ☐ Yes,

☐ Currently ☐ Within the last 12 months ☐ Within a lifetime

Health concerns: (check all that apply)

□ allergies	□ blood pressure problems	□ cancer
□ chronic pain	□ diabetes	□ eating disorder
□ HIV/AIDS	□ heart disease	□ Hepatitis A
□ hepatitis B	□ Hepatitis C	□ history of head injuries
□ history of seizures	□ history of seizures/epilepsy	□ jaundice
□ kidney disease	□ lice/scabies	□ liver disease
□ respiratory problems	□ sexually transmitted illness	
□ stomach/gastrointestinal problems	□ tuberculosis	

Drugs Currently Prescribed:

List ALL (prescribed & OTC) medication by classification (e.g. antidepressant, diuretic) currently being used by the client:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Supplemental Referral Information Form

Client Name _____ DOB (dd/mm/yy) _____ Date _____

Client's confirmed post treatment accommodations (applicable primarily to short cycle programs) ☐ Returning home **or**

Other—Add Details _____

Note: Complete the Referral Agent info only if you're using printed Catalyst screens because they do not list your personal information.

Referring Agency _____ Phone # _____ Ext. ____ Fax # _____

Contact _____ E-mail Address _____

Client's Detoxification Information/Plan:

Client will detox for a minimum of _____ hours prior to admission. **(Check individual facility for min. standards.)**

Detoxification will occur with the support of (check if applies and add contact information):

☐ WMS facility _____ Phone # _____ Ext. _____

☐ Community WMS support _____ Phone # _____ Ext. _____

☐ Family/significant others _____ Phone # _____

☐ Other (specify) _____

Client's Contact Information (Emergency contact required, others as applicable):

Emergency contact _____ Phone # _____

Family/Prescribing Doctor _____ Phone # _____

Psychiatrist _____ Phone # _____

Probation/Parole Officer _____ Phone # _____

Other Information:

Prior attempts/ideation of suicide/self-harm: □ No ☐Yes (provide details) _____

_____

Pending criminal charges ☐ No ☐ Yes (details & court date) _____

Prior treatment history (where & when) _____

_____

Consent to Release/Request Information:

I, (client name) _____, consent to the exchange of information between

_____ and Addictions and Mental Health Services Hastings Prince Edward

for the purpose of arranging my referral and/or admission to addiction treatment and to provide discharge information.

Client _____ **Counsellor** _____ **Date** _____