YOUTH RECOVERY HOUSE INTAKE APPLICATION

info@thebridgeservices.ca | Phone: 250 763 0456 Fax: 250 763 4910

Applicant's Community Health Authority:

☐ Interior Health ☐ Other ………………..…………………..

Who's making the referral? ☐ Self ☐ Parent / Guardian ☐ Health Authority Service Provider

☐ Community Service Provider ☐ Other ………………..…………………..

Name: ……………………………………………. Agency / Program …………………………………………..........

Phone: ……………………………………………. Email: ………………………………………….............................

Date: …………………………………………….

Youth Information

Legal Name:	Preferred Name:
Address:	
Phone: (call/text)	Email:
Date of Birth: (dd/mm/yy)	BC Care Card Number:
Gender:	Pronoun(s):
Parent(s) Names:	

Do you reside with your parents (s)? YES ☐ NO ☐ If not residing with parent (s) please provide the following info :

Legal Guardian:

Name: ………………………………………………………...... Phone: …………………………………………………......

Address: ………………………………………………………...... Email: …………………………………………………......

Caregiver:

Name: ………………………………………………………...... Phone: …………………………………………………......

Address: ………………………………………………………...... Email: …………………………………………………......

Relationship to Caregiver: (i.e. foster parent, aunt, friend, etc.)

Cultural Information

Ethnicity: _______________ First Language: _______________

Are there any communication barriers?: YES ☐ NO ☐ If yes, specify: _______________

____

Cultural specific care / practice: YES ☐ NO ☐ If yes, specify: _______________

____

Aboriginal Ancestry: YES ☐ NO ☐ Status: YES ☐ NO ☐ Status card Number: _______________

Substance Use and Treatment History

1. Have you ever been in a treatment program (including day programs) to get help with substance use?
   ☐ Yes ☐ No

   If yes, name of program? _______________

   Date: _______________ How long did you attend ?_______________

2. Please list the substances you identify as problematic in your life

   ____

3. What do you hope to accomplish during your time with us?

   ____

   ____

   ____

4. Please complete this chart to the best of your ability. You will be provided with on-site support for withdrawal (detox) as needed.

Substance	Method of use (smoke, IV etc.)	Date of first use (mm/yy)	Amount/Quantity used daily	# of days of use in the last 30 days	Date of last use (dd/mm/yy)

Mental and Physical Wellbeing

1.) Disordered eating (ie restricting, bingeing)? ☐ Yes ☐ No If yes, please describe:
2.) Self-injury behaviors (ie cutting, burning)?☐ Yes ☐ No If yes, please describe and include most recent date:
3.) Suicidal thoughts and/ or have attempted suicide? ☐ Yes ☐ No If yes, please describe:
4.) Aggression or anger toward others or history of harming others? ☐ Yes ☐ No If yes, please describe:
5.) Suspected or diagnosed mental health conditions? (e.g depression, PTSD, anxiety, FASD, ABI/TBI) ☐ Yes ☐ No If yes, please describe:
6.) Suspected or diagnosed physical concerns? (e.g. seizures, kidney/liver issues) ☐ Yes ☐ No If yes, please describe:
7.) Allergies. (e.g. food, medication, environmental) ☐ Yes ☐ No If yes, please describe:
8.) Have you been hospitalized for any reason in the last year? ☐ Yes ☐ No If yes, please describe:
9.) Do you have any health concerns that may impact your ability to participate fully in programming? (Let us know if you require specific accommodation)

Care Team

We work collaboratively with all professionals who are part of the youth's care team. We encourage all community supports to remain involved with the young person throughout their time with Youth Recovery House.

Social Worker:

Name: | Phone:

Email Address:

Probation Officer:

Name: | Phone:

Email Address:

Mental Health Worker:

Name: | Phone:

Email Address:

Family Support Worker:

Name: | Phone:

Email Address:

Psychiatrist:

Name: | Phone:

Email Address:

Physician:

Name: | Phone:

Email Address:

Other Professionals:

Name: | Phone:

Email Address:

Name: | Phone:

Email Address:

Legal History

1.) Do you have any outstanding charges? ☐ Yes ☐ No If yes, please list:

2.) Do you have any upcoming court dates? ☐ Yes ☐ No If yes, When?

3.) Are you currently on probation? ☐ Yes ☐ No If yes, please send copy of probation order with application

Education

Participating in education is part of the wellness program

Are you currently attending school? ☐ Yes ☐ No

If no, when and where were you last attending school?

Date last attended: ________________________________

School Name & District: ____

School contact or resource Name: ____

Phone Number: ________________________________

Housing / Accommodation

Please tell us about your current and post treatment housing.

Do you currently have safe housing? ☐ Yes ☐ No If no, please describe safety concerns:
Are you currently homeless? ☐ Yes ☐ No If yes please describe situation:
Do you have safe housing or accommodation arranged for after treatment? ☐ Yes ☐ No If no, please indicate any housing options you are interested in or referrals recently submitted:
How will you travel home?

Early Leave and Discharge Plan

It is understood that if for any reason I leave The Bridge early , the following person or agency will pick me up:

Name: ____

Agency: ____

Address: ____

Phone Number: ____

In the event the above is not the youth legal guardian or caregiver, consent is required.

____	____
Legal Guardian/ Caregiver Name	*Legal Guardian / Caregiver Signature*

It is understood that if I leave the program early or if I do not arrive for my scheduled intake, my referral liaison and my legal guardian will be notified immediately.

____	____
Youth Name	*Youth Signature*

PRE – Admission Medical Status Questionnaire

To be Completed by a Physician

Patient Information:

First Name: ______________________________ Last Name: ______________________________

Health Card #: ______________________________ Date of Birth: ______________________________

City & Province: ______________________________ Phone #: ______________________________

Height: ________________ Weight: ____________ BP: ______________ Pulse: ____________

Drug/Food Allergy: ____

Medication:

Please check all categories representing types of prescription medication that are currently being used:
☐ Anti-depressant ☐ Anti-anxiety ☐ Anti-psychotic ☐ Pain Medication ☐ Other: ______________

Methadose/ Suboxone/ Kadian:

Length on program: Current dose: ____________ml/mg

Length of time on current dose: ________________________________

Prescribing Physician Name: ____________________________ Phone #: ____________________

Medical History:

Symptoms/ conditions/ diagnosis:	

Has the patient suffered seizure in the past year? ☐ Yes ☐ No
If yes, is the seizure withdrawal related? ☐ Yes ☐ No
If not withdrawal related, do they have a seizure disorder? ☐ Yes ☐ No
If yes, please describe:
____

This patient is medically and physically capable of participating in a facility-based program for problematic substance use

________________________________ ________________________________
Doctor's Name Signature

________________________________ ________________________________
Phone Number Fax Number

Date: ____________________

Prescription Form

To be Completed by a Physician

Dear Doctor:

Your patient has applied to the Youth Recovery House. Please write out all orders to facilitate admission to our program. We require participants to bring originals of all triplicate prescriptions or to have them faxed directly to the Recovery House prior to the admission date. (Fax: 250 763 4910)

Our staff can only administer prescription and over-the-counter medications (including vitamins) that are prescribed by a physician or nurse practitioner and dispensed directly to us through our pharmacy.

The length of stay will depend on the goals outlined by your patient. **We require 30 days of medication to start**:

Date: ______________________________

Patient Name: ____

PHN # : ____

DOB: ____

Drug Allergies: _______________________________________

Rx:

MEDICATION (TO BE BLISTER PACKED)	INSTRUCTION FOR USE	ORDERS AUTHORIZED FOR 30 DAYS UNLESS OTHERWISE SPECIFIED – PLEASE SPECIFY QUANTITY FOR NARCOTICS

Physician Signature: ____

Physician Name (Print): _______________________________________

License #: ____

Telephone Number: ____

To Be Completed by Referring Agent

1.) What are the key areas of concern, as agreed upon by you and your client?

2.) Please describe the young person's strengths.

3.) How long have you been working together?

4.) How many sessions have you had together?

5.) What goals would you identify as an area of focus during their stay with us? Please let us know of any work or planning that has been developed and/or initiated so that we can support the care planning for this youth.

6.) Our program offers family counselling services to all youth and their family; is there any reason you are aware of that this would be contra-indicated for this young person?

7.) Have you engaged in family work prior to this referral?

8.) Why do you think the Youth Recovery House is the right fit for this young person?

9.) Please indicate any barriers you think impact this youths 'ability to participate in the program. From your perspective, how might the Youth Recovery House best support their success?

Referring Agent Name__________________________ Signature_______________________Date:________________

To Be Completed by Parents/ Legal Guardians or Primary Caregiver

Your Name: ____

Relationship to youth: ____

1.) Is the youth experiencing struggles in addition to substance use?

2.) What are their strengths?

3.) What are the family's strengths?

4.) Your continued support throughout the program is important and encouraged. Communications may include telephone and video conferences, family meetings, family night, visits and planned participant passes. Please indicate if you have any concerns or if there are barriers that would interfere with your involvement.

5.) Is there anything else you would like to share with us?

6.) Is there any mental or physical health concerns that you would like us to be aware of?

Consent for Referral and Release of Information

I have read and understand the referral forms. I acknowledge that the Youth Recovery House is a voluntary program and this application is being made with my consent and approval.

Participant: ______________________________ ______________________________
(Please print name) *(Signature)*

Witnessed by: ______________________________ ______________________________
(Please print name) *(Signature)*

Recovery House staff may need to clarify or obtain additional information. By signing below you consent that we have your permission to contact people listed in your application should we need to do so. This consent is valid for three months unless you advise us otherwise.

Participant: ______________________________ ______________________________
(Please print name) *(Signature)*

Date: ______________________

Witnessed by: ______________________________ ______________________________
(Please print name) *(Signature)*

Date: ______________________

Is there any person listed on your application that you do not give us permission to speak with? Please list below: