Referral to Adult Addictions Services

Sister Margaret Smith Centre

301 Lillie St. N. Thunder Bay, ON P7C 0A6
Tel: 807-684-5100

- ☐ Live-In Addiction Treatment
- ☐ Outpatient Addiction Services
- ☐ Addiction Day Treatment

Sister Margaret Smith Centre requires referrals to be completed by a counsellor and accompanied by an assessment for live-in treatment referrals.

Crossroads Centre

500 Oliver Rd. Thunder Bay, ON P7B 2H1
Tel: 807-622-2730

- ☐ Pre-Addiction Treatment
- ☐ Post-Addiction Treatment

Send completed referrals to:

Mail: 301 Lillie St. N.
Thunder Bay, ON P7C 0A6
Fax: 807.622.1779
Email: sjcg.smsccrossroadsintake@tbh.net

Lodge on Dawson

1460 Dawson Rd. Thunder Bay, ON P7G 1H8
Tel: 807-625-5409

- ☐ Transitional Housing Program
- ☐ Stabilization

Lodge on Dawson Transitional Housing Program requires a Service Prioritization Decision Assistance Tool (SPADAT) and an Application for Rent-Geared-To-Income Housing Assistance to be completed and submitted to Thunder Bay District Social Services Administration Board (TBDSSAB).

Send completed referrals to:

Mail: 1460 Dawson Rd.
Thunder Bay, ON P7G 1H8
Fax: 807.625-6521
Email: sjcg.LODReferrals@tbh.net

ST. JOSEPH'S CARE GROUP

Care Compassion Commitment

THUNDER BAY INTEGRATED ADDICTION AND MENTAL HEALTH SERVICES
CONSENT TO OBTAIN / RELEASE INFORMATION

The protection of your privacy and the delivery of high quality care is our priority. In order to best serve you, a group of service providers, all committed to the protection of your privacy, are working together to support your decisions regarding your care. With your permission, we will share information with each other and with other agencies to support you in developing a plan of care that is designed to support your choices and decisions.

The following agencies are part of a service system which is designed to support you in reaching your personal goals.

Thunder Bay Counselling
Addiction Services, Thunder Bay, ON ______

St. Joseph's Care Group
Addiction & Mental Health Services
Thunder Bay, ON ______

Alpha Court Community Mental Health &
Addiction Services, Thunder Bay, ON ______

St. Joseph's Care Group
Crossroads Centre Thunder Bay, ON ______

Dilico Anishinabek Family Centre
Mental Health and Addictions
Services Thunder Bay, ON ______

If you are in agreement for the above named agencies and related programs to share assessment, treatment and case management information, please indicate your authorization by **initialing beside each relevant agency**.

In addition, there may be cause to share your personal health information with other care providers and agencies to support you in meeting your personal goals. If you are in agreement for the agencies listed below to obtain/release information with the authorized agencies in Thunder Bay Integrated Addiction and Mental Health Services please sign beside each agency indicating your authorization.

Consent to release/request information from the persons/agencies below:	Date	Signature
1. Electronic Medical Record (EMR) TBRHSC & SJCG	______	______
2. Consent to email referral package between agencies	______	______
3. ______	______	______
4. ______	______	______

Having read and understood this form, I hereby authorize the identified agencies of Thunder Bay Integrated Addiction and Mental Health Services to Release/Request Information to/from each other and to/from the persons/agencies listed above. I also understand that I can withdraw my consent in writing at any time and that I can restrict the nature and type of information shared. This consent is considered valid for a period of six (6) months from the date of signature when it will be reviewed and renewed as required.

______
Name (Please Print) D.O.B. (dd/mm/yyyy) Signature

______ ______
Reviewed and Witnessed By Date

Substitute decision maker (Please Print)______

Signature:______ Date:______ Relationship: ______

THUNDER BAY ADDICTION AND MENTAL HEALTH SERVICES GUIDELINES FOR COMPLETING FORM

- Clinician / Case Manager will review the Consent to Obtain/Release Information with the client and address any questions/concerns prior to obtaining a signature
- Clinician / Case Manager will review the Consent to Service prior to obtaining client signature
- Copy of the Consent to Service and Consent to Obtain/Release Information will be filed on the clients' record
- The receiving agency conducting the initial intake will also provide a copy of their agency's privacy statement

St. Joseph's Care Group

Care Compassion Commitment

CLIENT INFORMATION FORM	REFERENT INFORMATION
FIRST NAME: **MIDDLE NAME:**	**DATE OF REFERRAL:** **REFERRING AGENCY:**
LAST NAME: **LAST NAME AT BIRTH:** **EMAIL ADDRESS:**	
DOB: DD/MM/YEAR **AGE:**	**NAME OF REFERENT:** **EMAIL:**
GENDER:	
HEALTH CARD # : **PROVINCE:**	**AGENCY ADDRESS:** **POSTAL CODE:** **PHONE:** **FAX#:**
NO FIXED ADDRESS **MAILING ADDRESS:** **STREET:** **CITY:** **PROVINCE:** **POSTAL CODE:**	
HOME PHONE # : **OTHER PHONE #:** **CALL ALLOWED:** YES NO **MESSAGE ALLOWED:** YES NO **PREFERED LANGUAGE:** English French Other	**CLIENT TYPE – PLEASE CHECKMARK** Client- Alcohol/Drug Client- Alcohol/Drug/Gambling Client- Gambling Family member of Alcohol/Drug Client Family member of Alcohol/Drug/Gambling Client
EMERGENCY **CONTACT:** **RELATIONSHIP:** **PHONE #:**	**ETHNICITY- ETHNIC OR CULTURAL IDENTITY:** PRIMARY STATUS # BAND

ST. JOSEPH'S CARE GROUP

Care Compassion Commitment

PLEASE CHECKMARK IN EACH SECTION THAT BEST FITS:

1. TREATMENT MANDATED\REQUIRED BY:

None
Choice between treatment or jail
Condition of probation/parole
Child Welfare Authority
Condition of employment
Condition of school
Condition of family
Other ________________

2. LEGAL STATUS:

No problem
Awaiting trial\sentencing
On probation- Start date: __________________ DD-MM-YYYY) End date:____________________ (DD-MM-YYYY)
On parole - Start date: __________________ (DD-MM-YYYY) End date:____________________ (DD-MM-YYYY)
Incarcerated
Other ________________

3. RELATIONSHIP STATUS:

Married/partnered/common-law
Spouses Name: _____________
Single (never married)
Widow or widower
Separated or divorced

4. EMPLOYMENT STATUS:

Employed full-time (includes self-employment)
Employed part-time
Unemployed (looking for work)
Student\ retraining
Program: _______________
Disabled (not working)
Not in labour force
Retired

5. HIGHEST LEVEL OF EDUCATION:

No formal schooling
Some primary school
Primary school
Some high school
Completed high school
Some college
Completed college
Some university
University degree

6. INCOME SOURCE:

Disability insurance (WSIB)
Employment
Employment insurance
Family Support
None
ODSP
Ontario Works
Other Insurance
Retirement
Other _______________________

7. PARENTING (CUSTOM FIELD)

Yes, with 1 or more child aged 0-6 years
Yes, with no children aged 0-6 years
Children in care of others
No children

SUBSTANCE USE & GAMBLING HISTORY

PRESENTING PROBLEM SUBSTANCES:

	SUBSTANCE USED	FREQUENCY IN LAST 30 DAYS- CHECKMARK ONE
MAJOR SUBSTANCE		Did not use 1-3 times monthly 1-2 times weekly 3-6 times weekly Daily Binge Age of 1st use: Age regular use began:
1ST OTHER SUBSTANCE		Did not use 1-3 times monthly 1-2 times weekly 3-6 times weekly Daily Binge Age of 1st use: Age regular use began:
2ND OTHER SUBSTANCE		Did not use 1-3 times monthly 1-2 times weekly 3-6 times weekly Daily Binge Age of 1st use: Age regular use began:

OTHER SUBSTANCES USED IN PAST 12 MONTHS: (checkmark all the ones that apply)

Alcohol
Amphetamines
Barbiturates
Benzodiazepines
Cannabis
Cocaine
Crack
Ecstasy
Glue /Inhalants
Hallucinogens
Heroin\ Opium
Methamphetamines (Crystal Meth)
Other Psychoactive drugs
Over-the-counter codeine products
Prescription Opioids
Steroids
Tobacco
Unknown
None

GAMBLING ACTIVITIES ENGAGED IN THE PAST 12 MONTHS:

Bingo - live/TV/radio
Slot machines
VLT's/ other gaming machines
Casino- Card/Table Games
Non-Casino Card/Table Games
Horse races-live/off-track
Sports betting (including Pro Line)
Lottery tickets
Instant win/scratch tickets (i.e. break open, pull tab, Nevada strips)
Internet Gambling
Gambling with Stocks/Options/Commodities/Real estate
Betting on games of skill i.e. pool, pitching pennies
Betting on the outcome of events
Other ______________________
None
Unknown

IS GAMBLING IDENTIFIED AS A PROBLEM? YES NO

HEALTH STATUS/PROBLEMS

Visual impairment: **YES** **NO**

Hearing impairment: **YES** **NO**

Mobility/ physical impairment: **YES** **NO**

Pregnant: **YES** **NO** **UNSURE**

Non-medical intravenous drug use:
Never injected
Injected prior to one year
Injected in last 12 months

Reason for most recent hospitalization: ________________________ Date: ________________________

Diagnosed with a mental health problem by a mental health professional:

-within the past 12 months- **YES** **NO**

-within lifetime- **YES** **NO**

-most recent diagnosis- ____

Hospitalized for a mental health problem?

-within the past 12 months- **YES** **NO**

-within lifetime- **YES** **NO**

Received counselling/support/treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

-currently- **YES** **NO**

-within the past 12 months- **YES** **NO**

-within lifetime- **YES** **NO**

-name of current service provider: ____

-contact information for service provider: ____

ST. JOSEPH'S CARE GROUP

Care Compassion Commitment

HEALTH CONDITIONS

Please check all that apply:

Allergies

Blood pressure problems
Cancer
Chronic pain
Diabetes
Eating disorders (anorexia, bulimia,over eating) HIV/AIDS
Heart disease
Hepatitis A
Hepatitis B
Hepatitis C
History of head Injuries/concussion
History of seizures/epilepsy

Jaundice
Kidney disease
Lice/scabies
Liver diseases
Menstrual/menopausal difficulties
Pancreatitis
Respiratory
STD (syphilis, gonorrhea, chlamydia, Herpes)
Stomach/gastrointestinal problems
Thyroid problems
Tuberculosis

Provider of Primary Health care (doctor, nurse practitioner, health clinic): ___________________________

Contact information for provider of health care: ____

PRESCRIBED DRUGS

On Methadone or Suboxone: **YES** **NO** Prescriber: ___________________________

Prescribed Drug	Prescriber & Phone #	Prescription Details

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING HEALTH STATUS:

REFERENTS COMPLETE:

REFERRAL INFORMATION:

1. What circumstances have made the client request treatment at this time?

2. What supports are you providing? How long have you been working with this client? Is therapy/counseling on going?

3. What supports does the client have access to in the community? What supports/services has the client accessed to date? (If the client has not accessed services please explain why)

TREATMENT HISTORY

1. Has the client previously tried to quit or cut down on their substance use or gambling?

No Yes How many times?

What were the circumstances that caused the client to make changes with his/her use during these times?

2. What has been the longest period of non-using? What did the client find helpful during those periods?

3. What do you identify as the reasons for returning to drinking/drug using/gambling?

4. What is the client's current substance use or gambling goal?

quit all substance use/gambling
maintain abstinence
other__________________________

cut down on ___________________________
make no changes

5. Previous addiction treatment- No previous treatment attempts-
Yes, **FILL IN TABLE BELOW**

NAME OF FACILITY	DATE	TYPE OF TREATMENT	COMPLETED?

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING TREATMENT HISTORY:

EMOTIONAL HEALTH

PLEASE ANSWER YES OR NO AND PROVIDE INFORMATION ON HOW THE CLIENT HAS COPED AND WHAT SUPPORTS HAVE BEEN UTILIZED

CONCERN	EXPERIENCED IN LAST 90 DAYS	EXPERIENCED IN LIFETIME	SUPPORTS/COPING SKILLS USED
Anxiety- tension, nervousness fears / phobias			
Depression- grief, losses, isolation			
Eating disorders- starving on purpose, binging/purging			
Sexual abuse / sexual assault			
Physical, emotional, mental abuse			
Suicide- suicidal thinking, attempts, self-harm behaviour			
Cognitive- difficulty tracking , concentrating, focusing			
Anger- assaults, aggressive behaviour			
Other trauma (deaths, accidents, other traumatic events)			

OTHER POTENTIALLY EXCESSIVE BEHAVIOURS:
PLEASE CHECK THE BOXES BELOW IF THEY ARE RELEVANT. PROVIDE DETAILS IN THE SPACE PROVIDED. *Ie. Amount of time spent doing this activity, negative life impact, causes financial strain, topic of arguments with loved ones).*

NONE

	☑	**DETAILS**
Shopping (excessive money spending)		
Internet overuse (surfing, chatting, blogging, social networking)		
Video Gaming (computer or home systems, online)		
Eating Disorder (starving on purpose, binging purging)		
Sex (pornography, excessive masturbating, visiting sex trade workers, preoccupation with sexual thoughts)		
Other		

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING EMOTIONAL HEALTH (INCLUDE ALL MENTAL HEALTH DIAGNOSIS DETAILS):

FAMILY/SUPPORTS

1. What community is the client originally from? ____

2. Childhood Experiences:

Substance abuse	Neglect
Witness to domestic violence	Divorce/separation of parents
Emotional, physical or sexual abuse	Death of a parent
Foster Care	Happy home life

3. How does the client describe the current relationship with his/her family of origin?

4. Relationship Experiences:

Never been in a relationship	Difficulties talking about feelings
Affairs	Violence/abuse
Mental health issues of partner	Solid/supportive relationship

5. If the client is currently in a relationship, does the partner struggle with any addiction issues? Please describe.

6. Does the client have any children? Yes No
   If yes, who has custody of the children? What is the nature of the relationship with the children?

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING FAMILY, CHILDREN, AND SUPPORTS:

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Care Compassion Commitment

EMPLOYMENT / EDUCATION / LEGAL

1. Current or last occupation?

2. Does the client have EAP in the workplace?

3. Does the client have a history of learning disabilities or problems? YES NO
   If yes, what type:

4. Are there any literacy issues? YES NO

USE THIS SPACE TO PROVIDE MORE DETAIL ON EDUCATION & EMPLOYMENT:

LEGAL

1. Any current charges? YES NO When is the next court date?
2. If yes, are you on bail? YES NO What are the charges?
3. Are you on the Sex Offender Registry? YES NO
4. Do you have any no contact orders? YES NO
5. Have you, or are you currently banned from an emergency shelter? YES NO
6. If on probation or parole:
   What charges is the client on probation for?

   Probation or parole officer's name & contact info:

7. Past Offenses (check all that apply):

   - Theft / possession of stolen property
   - Drug charges
   - Weapons offenses
   - Robbery
   - Arson
   - Impaired driving
   - Murder / manslaughter, criminal negligence causing death
   - Other – (specify):
   - Parole / probation violations
   - Forgery
   - Burglary, break & enter
   - Assault
   - Sexual assault / incest
   - Willful damage / mischief

USE THIS SPACE TO PROVIDE MORE INFORMATION ON LEGAL:

Signature of Client ____________________ Date ____________________

Signature of Counsellor ____________________ Date ____________________