**Referral to SOAR Bed-Based and Day Treatment Acknowledgement**

**Referral & Intake Information – Bed-Based Addictions Program**

**Important Notes for Referrers:**

* **Self-referrals are not accepted.**
* Referrals must include a **client-signed consent to disclose.**
* Questions based on referral content will be directed to the **referring party**; clients will be contacted **after eligibility is confirmed**.

**To Review with Client Before Referral:**

* **Ongoing Contact:** Eligible clients must check in **weekly** via email (rtintake@soarcs.ca) or phone (519-753-4527) to stay on the waitlist.
* **Support While Waiting Group:** Weekly virtual group (Thursdays, 6–7 PM via MS Teams) is required for waitlisted clients. Attendance counts as the weekly check-in. Group covers:
	+ Accessing interim support (crisis, community)
	+ Program expectations
	+ Packing and preparation info

**Program Overview:**

* **Duration:** 5 weeks
* **Group Therapy:** 5 hours/day (Mon–Fri)
* **Additional Programming:** 3 hours/day (peer support, recreation, education)

**Medication:**

* Clients must bring a **5-week supply** or have scripts sent to HOPE Pharmacy Brantford (Fax: 519-286-9294).
* **No medication changes** during treatment.

**Facility Guidelines:**

* **Smoking:** Permitted outdoors only, between 6:00 AM–11:00 PM. No vaping, chewing tobacco, or cannabis.
* **Phones:** Accessible **1 hour per evening only.**

**Behaviour Expectations:**

* Respectful, inclusive conduct is mandatory.
* No discrimination, hate speech, or disruptive behaviour.
* **No substance use, possession, or sales** on-site.

Your signature on this form indicates that you have reviewed the above information with the client and all parties understand these expectations.

Referring Party’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Party’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the client has completed a recent GAIN Q3 or ADAT assessment, please attach it to the referral. If not, only the referral form and consent is required.

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| Referral for: [ ] Bed-Based Treatment [ ] Day Treatment  |
| DEMOGRAPHICS  |
| First Name:  | Last Name: | D.O.B yyyy/mm/dd: | Gender: |
| Health Card Number: | Address (Street, City, Postal Code):(Is this address any of the following): [ ]  No [ ] Shelter [ ] NFA [ ] Supportive/Transitional Housing |
| Email: | Phone Number: Permission to: [ ] Call [ ] Leave Voicemail [ ]  Text |
| Languages Spoken and Understood:Preferred Language for Services: | Do you identify as an Indigenous Person? *(Indigenous refers for First Nations, Metis, and Inuit peoples of Canada)*[ ]  Yes, First Nations[ ]  Yes, Metis[ ]  Yes, Inuit[ ]  No[ ]  Prefer not to answer |
| **Referral Source:**  | **Referring Party’s Name:** | **Referring Party’s Phone Number:** | **Referring Party’s Email:** |

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| PHYSICAL HEALTH SCREENING  |
| Does the client have any physical health diagnoses? [ ] Yes [ ] NoIf yes, please describe: | Does the client have any allergies? [ ] Yes [ ] NoIf yes, specify: |
| Has the client’s physical health prevented them from completing tasks of daily living within the past three months? (Ex. eating, chores, bathing, toileting) [ ] Yes [ ] NoIf yes, please describe: | In relation to the client’s physical health, is there any concern for the client’s ability to maneuver group dynamics in a classroom setting or in a group living environment? [ ] Yes [ ] No If yes, specify:  |
| Is the client currently struggling with any of the following:[ ] Vision[ ] Hearing[ ] Mobility | Is there any chance the client could be pregnant? [ ] Yes[ ] No |
| Has the client had any hospital visits within the past three months in relation to physical health? [ ] Yes [ ] NoIf yes, what for? | Does the client have any ongoing specialist appointments, surgeries, or procedures that may occur within the next three months? [ ] Yes [ ] NoIf yes, note date/time and purpose of appointment: |

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| MENTAL HEALTH SCREENING |
| Does the client have any mental health diagnoses? [ ] Yes [ ] NoIf yes, describe: |
| Is the client currently receiving any treatment for mental health? [ ] Yes [ ] No If yes, specify.  | How often in the past three months has the client struggled with their mental health symptoms? ☐Monthly☐Weekly☐Multiple times weekly☐Daily☐Multiple times daily |
| Has the client’s mental health kept them from maintaining their daily responsibilities within the past three months? [ ] Yes [ ] NoIf yes, describe: | How would the client’s current mental health affect their ability to manage group dynamics in a classroom setting or in a group living environment?  |

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| Medication List  |
| Medications | Dose | Reason | Comments (including if taking them as prescribed) |
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| Have you experienced any of the following in the past 12 months? |
| Issue | Yes | No | Please describe (including coping strategies, safety plan, etc.) |
| Anxiety |  |  |  |
| Depression |  |  |  |
| Difficulty Sleeping |  |  |  |
| Fears/Phobias |  |  |  |
| Feeling that people are against you or trying to harm you |  |  |  |
| Feeling aggressive/violent towards others |  |  |  |
| Seeing or hearing things that are not there |  |  | If yes, are these things disturbing? [ ] Yes [ ] NoIs the client aware of when they are happening? [ ] Yes [ ] No |
| Emotional Dysregulation |  |  |   |
| Self-Harm Behavior |  |  | How? When? |
| Thoughts of Suicide |  |  |  |
| Suicide Attempt(s) |  |  | If yes, when? |
| Financial Concerns |  |  | When? |
| Eating Disorders: Does the client have disordered eating behaviour (i.e. eating disorder)? [ ] Yes [ ] NoIf yes, respond to the following questions: |
| Does the client’s eating behaviour negatively affect their activities of daily living?   |
| How would the client’s eating habits be affected by group living dynamics? |

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| SUBSTANCE USE  |
| What substances has the client used in the past 12 months and how frequently do they use them? |
| **Substance** | **Frequency** | **Typical Quantity**  | **Method of Use** (ORAL, INHALATION, INJECTION) | **Last Use** |
|  | [ ] Monthly[ ] Weekly[ ] Multiple times weekly[ ] Daily[ ] Multiple times daily |  |  |  |
|  | [ ] Monthly[ ] Weekly[ ] Multiple times weekly[ ] Daily[ ] Multiple times daily |  |  |  |
|  | [ ] Monthly[ ] Weekly[ ] Multiple times weekly[ ] Daily[ ] Multiple times daily |  |  |  |
|  | [ ] Monthly[ ] Weekly[ ] Multiple times weekly[ ] Daily[ ] Multiple times daily |  |  |  |
|  | [ ] Monthly[ ] Weekly[ ] Multiple times weekly[ ] Daily[ ] Multiple times daily |  |  |  |
| Are there any substances that the client has successfully recovered from (abstained/reduced)? [ ] Yes [ ] NoIf yes, describe: | Has the client been hospitalized due to substance use, withdrawal, or opioid poisoning in the past three months? [ ] Yes [ ] NoIf yes, specify:  |
| Has the client attended substance use services/treatment in the past? [ ] Yes [ ] NoIf yes, please specify:  |

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| LEGAL |
| Does the client currently have any legal issues? [ ] Yes [ ] NoIf yes, select all that apply:* Probation
* Parole
* Bail
* Awaiting Trial
* House Arrest
* Incarcerated
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | Are the client’s legal issues related to weapons, violence, or arson? [ ] Yes [ ] No If yes, specify. |

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| SOCIAL SUPPORTS |
| Does the client currently have support from family/friends/community? [ ] Yes [ ] No If yes, please describe:  |
| READINESS FOR CHANGE |
| On a scale of 1 to 10, with 1 being ‘not at all’ and 10 being ‘very’, how important is it for the client to change their substance use? [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10  | On a scale of 1 to 10, with 1 being ‘not at all’ and 10 being ‘very’, how confident is the client in their ability to make changes to their substance use?[ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10  |
| Describe the client’s level of motivation to attend intensive bed-based treatment services.  |
| Is anyone mandating or pressuring the client to attend treatment? [ ] Yes [ ] NoIf yes, who and why? |

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| Post Bed-based Treatment Support Plan |
| What is the client’s care plan post bed-based treatment services? Will the client maintain connection to their referring party?  |