**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 No  If yes, please describe: | Does the client have any allergies?  Yes No  If 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 No  If 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 No  If yes, what for? | Does the client have any ongoing specialist appointments, surgeries, or procedures that may occur within the next three months? Yes No  If yes, note date/time and purpose of appointment: |

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| MENTAL HEALTH SCREENING | |
| Does the client have any mental health diagnoses? Yes No  If 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 No  If 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 No  Is 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 No  If 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 No  If yes, describe: | | | Has the client been hospitalized due to substance use, withdrawal, or opioid poisoning in the past three months? Yes No  If yes, specify: | |
| Has the client attended substance use services/treatment in the past? Yes No  If yes, please specify: | | | | |

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| LEGAL | |
| Does the client currently have any legal issues? Yes No  If 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 No  If 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? |