VANCOUVER COASTAL HEALTH
CENTRAL ADDICTION INTAKE REFERRAL PACKAGE for
SUPPORTIVE TRANSITIONAL LIVING RESIDENCES (STLRs) and TREATMENT FACILITIES

Emerge, New Dawn, Together We Can & Pacifica

REFERRAL INFORMATION

VCH Supportive Transitional Living Residences (STLRs) and Treatment Facilities are live away (tier 4) substance use rehabilitation programs for clients aged 19+ with serious substance use issues and addictions. The programs are located in Vancouver and are generally 90 days in length.

The aim of these programs is to enhance the strengths and skills of substance dependent persons and to empower them, through interventions based on best practice to begin to live lives free of problematic substance use. STLRs and Treatment Facilities offer a substance use-free, structured environment and supportive opportunities to work on substance use related goals. The programs are abstinence-focused and require that clients commit to staying away from substance use while in the program.

REFERRAL CHECKLIST

This package is to be completed by a community counsellor, social worker or health care professional in collaboration with the client. Before submitting this package to the Central Addiction Intake team, please ensure the following tasks are complete:

The client and the community counsellor, social worker or health care professional have **reviewed, completed and signed**:

- ☐ Care Facility Admission Consent
- ☐ Complete Referral Assessment
- ☐ MSDPR Funding Verification Form
- ☐ Consent for Release of Information
- ☐ Care Plan

***Please note: CAIT referrals are only processed through IMITS online file transmission process. Instructions are provided in this information document on how-to upload a referral through IMITS; a secure file transmission sever that protects an individual's confidential information.**

QUESTIONS OR GENERAL INQUIRIES

The Central Addictions Intake Team
Phone: 604-675-2455 Ext. 22564 for Pacifica &Together We Can
Phone: 604-675-2455 Ext. 22563 for Emerge & New Dawn
Hours of Operation: 8:30am-4:30pm, Monday to Friday

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PROGRAMS

Vancouver Coastal Health (VCH) works in partnership with and funds services that are provided by non-profit agencies. Each program offers a unique approach; we encourage referral agents to get to know these resources and to consider a best fit for your client. Additional information about each program can be found on the various program websites listed below:

STLRs

- **New Dawn** (women)..... http://www.chrysalissociety.com/BecomeAClient.aspx
- **Turning Point*** (all genders)..... http://www.turningpointrecovery.com/
- **Together We Can** (men)..... http://twcvancouver.org/
- **Emerge**(men)…..... http://www.cccares.org/addiction-recovery.html

Treatment Facilities

- **Pacifica Treatment Centre** (all genders)..... http://www.pacificatreatment.ca/

***Turning Point referrals are managed directly by the Turning Point Recovery. The referral package can be downloaded directly from their website noted above.

The various STLRs and Treatment Centers are gender-separated services. Respectful of gender diversity, we will work with clients to figure out how to provide services that respectfully treat them according to their self-identified gender and sexual orientation. All services welcome the LGBTTQ2I community.

Treatment Facilities offer a more tailored experience (e.g. all day programming) through individual and group work facilitated by counsellors that have advanced training (e.g. a Master's degree) to support people struggling with substance use issues and addictions.

CLIENT CONSIDERATIONS

Please review this section with your client when considering a STLR or Treatment Facility.

These programs may be helpful if you are age 19+ and:

- ☐ substance use is interfering or interrupting your life goals
- ☐ you want help to support your goals
- ☐ you are okay with participating in group work
- ☐ you are okay with living in a small supportive community with other individuals (STLR)
- ☐ you have spoken with a Community Counsellor, Social Worker or Health Care Provider to find out if you may benefit from a live away substance use service.

Call or email the CAIT team to discuss your situation if:

- ☐ if you have a significant brain injury
- ☐ you have a history of setting fires and this poses a current risk
- ☐ you have a history of being sexually and/or physically violent towards others and this poses a current risk
- ☐ you have active TB
- ☐ you need 24/7 physical care and help with basic daily activities (washing, eating, dressing)
- ☐ you have a life threatening medical condition that requires treatment in a hospital or medical restrictions
- ☐ you are required to attend off site and/or home based medical appointments/treatment
- ☐ you have been in custody within the last 6 months

As a referring service provider you play an important role in helping your client succeed as follows:

- ☐ Supporting client preparation, admission, engagement, retention, and therapeutic alliance
- ☐ Develop an interim support care plan (while waiting, ensure medications are stable, screen for withdrawal management concerns prior to intake, transportation planning, prescriptions ready for admission)
- ☐ Develop a discharge care plan prior to admission
- ☐ Contribute to the collaborative ongoing care plan and update the discharge care plan for the client as needed
- ☐ Maintain communication with client and their care team at the site

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CENTRAL ADDICTION INTAKE REFERRAL PACKAGE for

PRIVACY AND CONSENT

SUPPORTIVE TRANSITIONAL LIVING RESIDENCES (STLRs) and TREATMENT FACILITIES

Privacy at Vancouver Coastal Health Authority

- When you are receiving care from any of the programs or services at Vancouver Coastal Health Authority (VCH), personal information needs to be collected from you by counsellors, health care practitioners and other healthcare team members.
- We collect, use and share this information when required or permitted by law; for example, according to British Columbia's *Hospital Act*, *Hospital Insurance Act*, and the *Freedom of Information and Protection of Privacy Act* (FIPPA).
- Sometimes your family, friends, or someone who has the legal right to represent you, may also give us personal information about you.
- We may also need to get personal information from other sources, such as copies of your previous health records from other hospitals or from your family physician, or we may confirm your identity and personal health number (PHN) with the Ministry of Health.

Vancouver Coastal Health is ethically committed and legally required, to protect your personal information.

We are committed and legally required by *Freedom of Information and Protection of Privacy Act* (FIPPA) to protect your privacy. We use and share your information for authorized purposes and must store it securely to protect it. Our staff are trained on how to protect your privacy and to keep your personal information confidential at all times.

Who can look at, use, and share my personal information?

Someone who "**needs to know**" your information in order to provide care and other care-related services, is permitted to look at your personal information (like a counsellor or a nurse). They may use and share it for the following reasons:

- To assist with your ongoing care and services
- To contact you or your family about your medical care when appropriate
- To help us improve the quality of your care and services
- Research (when authorized)
- Teaching and education (of counsellors and nurses, for example)
- To see if you qualify for different benefits or services and to arrange payment.

Your personal information may also be shared with other people with your consent. However, we must provide it without your consent in some circumstances. These include:

- To respond to a court order or subpoena
- To comply with an insurance investigation by another government body such as WorkSafe BC
- To report or provide information to investigate a suspicion that a child or an older adult is being abused or neglected
- To report intention of self-harm or harm to another person

If you have any questions or concerns about the limits of confidentiality, you are encouraged to speak with your counsellor, health care provider, or the VCH Privacy Office (604-875-5568 or privacy@vch.ca). Our program is committed to being as open as possible about our responsibilities to both you and the community.

CENTRAL ADDICTION INTAKE REFERRAL ASSESSMENT BED BASED SUBSTANCE USE SERVICES (STLRs & Treatment)

INSTRUCTIONS:

This following referral package consists of 6 pages; all pages must be completed by a counsellor, social worker or health care professional who is supporting this individual with their on - going recovery goals and careplan.

The referral packages consists of the following forms - *all forms must be completed:*

1. **Cover Sheet - Referring clinician and individual's contact information.**
2. **Ministry of Health - Care Facility Admission Consent. This form provides informed consent to the client prior to admission into a recovery / treatment facility.**
3. **Assessment Form**
    a. **VCH referrals please complete the MHSU assessment on PARIS or EMR**
    b. **Non-VCH referrals - please complete the referral assessment form provided in this referral package.**
    Gather as much information as possible to support CAIT and the bed-based facility to identify client readiness for admission. A "TIPs" sheet is included to provide guidance only.
4. **Consent for Release of Information (top section).**
5. **Discharge Care Plan - please ensure that time and attention is given not only to facility placement but also to facility discharge planning.**
6. **MSDPR Funding Verification form - this form confirms that government funding is in place for the individual.**

SUBMITTING A REFERRAL:

VCH referrals-please submit completed referrals using the IMITS secure FTP application. Instructions on how to access and upload using the IMITS secure FTP application follow on the next 3 pages.

Contact CAIT, if you have not been given an individual login and password for IMITS use.

QUESTIONS & GENERAL INQUIRIES

The Central Addictions Intake Team

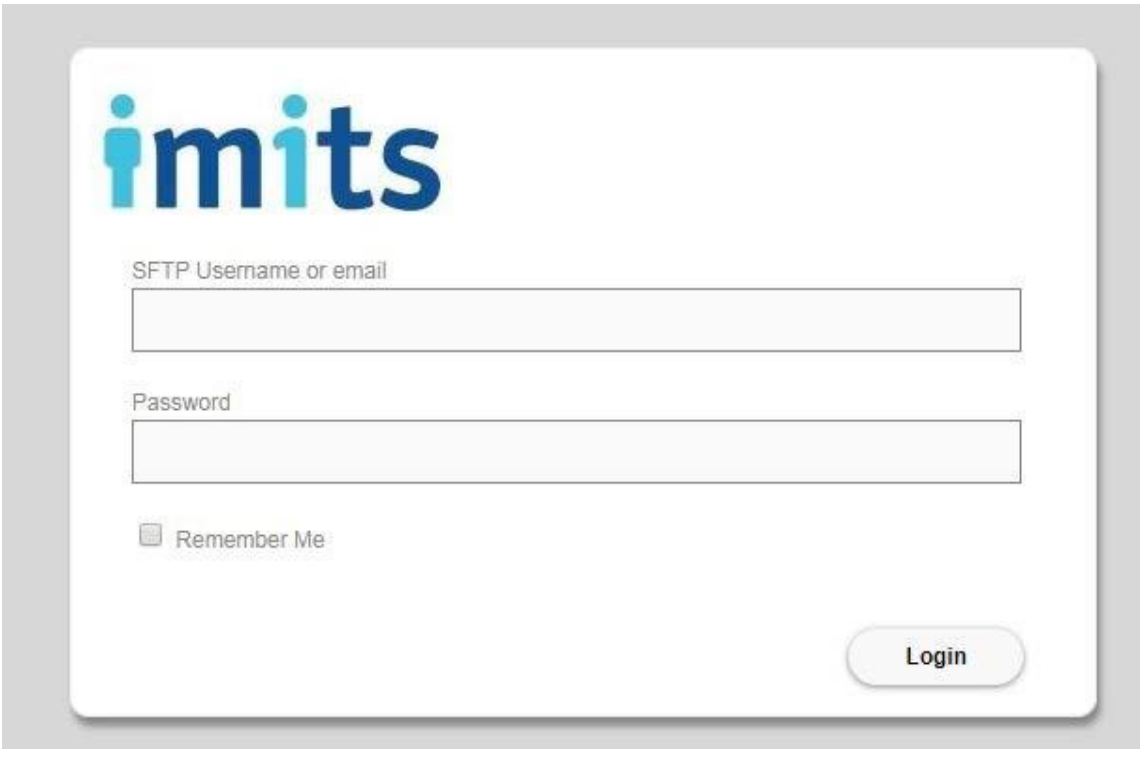
Phone: 604-675-2455 Ext. 22564 for Pacifica &Together We Can
Phone: 604-675-2455 Ext. 22563 for Emerge & New Dawn

Hours of Operation: 8:30am-4:30pm, Monday to Friday

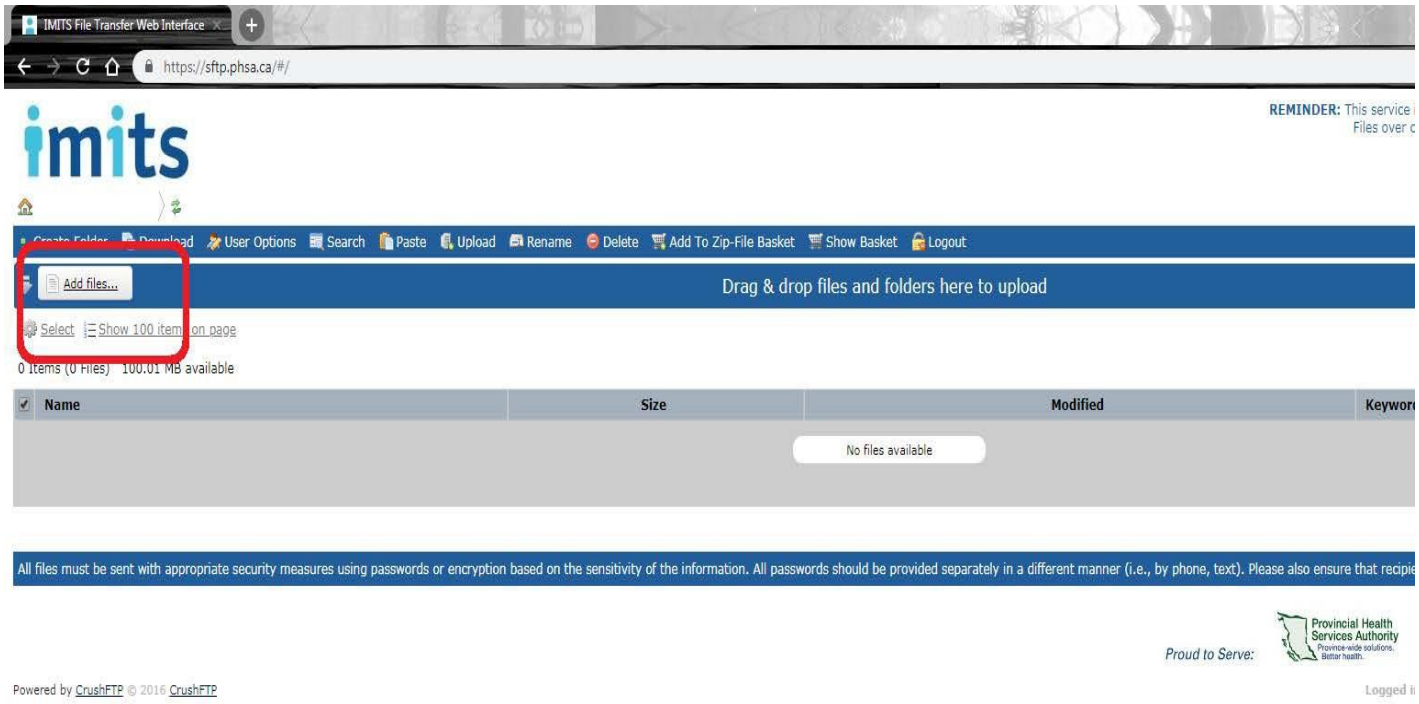
Sending Documents to CAIT via Secure Transfer Protocol (SFTP)

1. Navigate to the SFTP website at https://sftp.phsa.ca/WebInterface/login.html

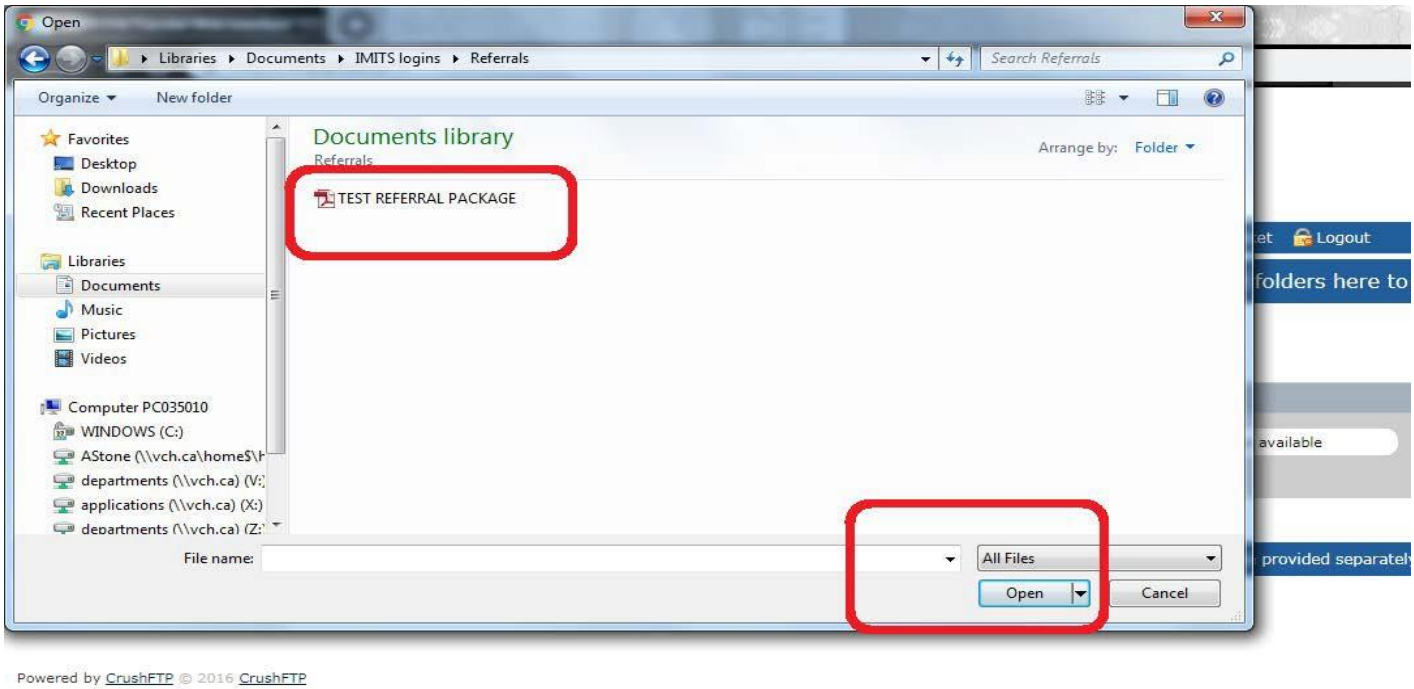
2. Log in to the SFTP user interface using the credentials provided to you by VCH-CAIT.



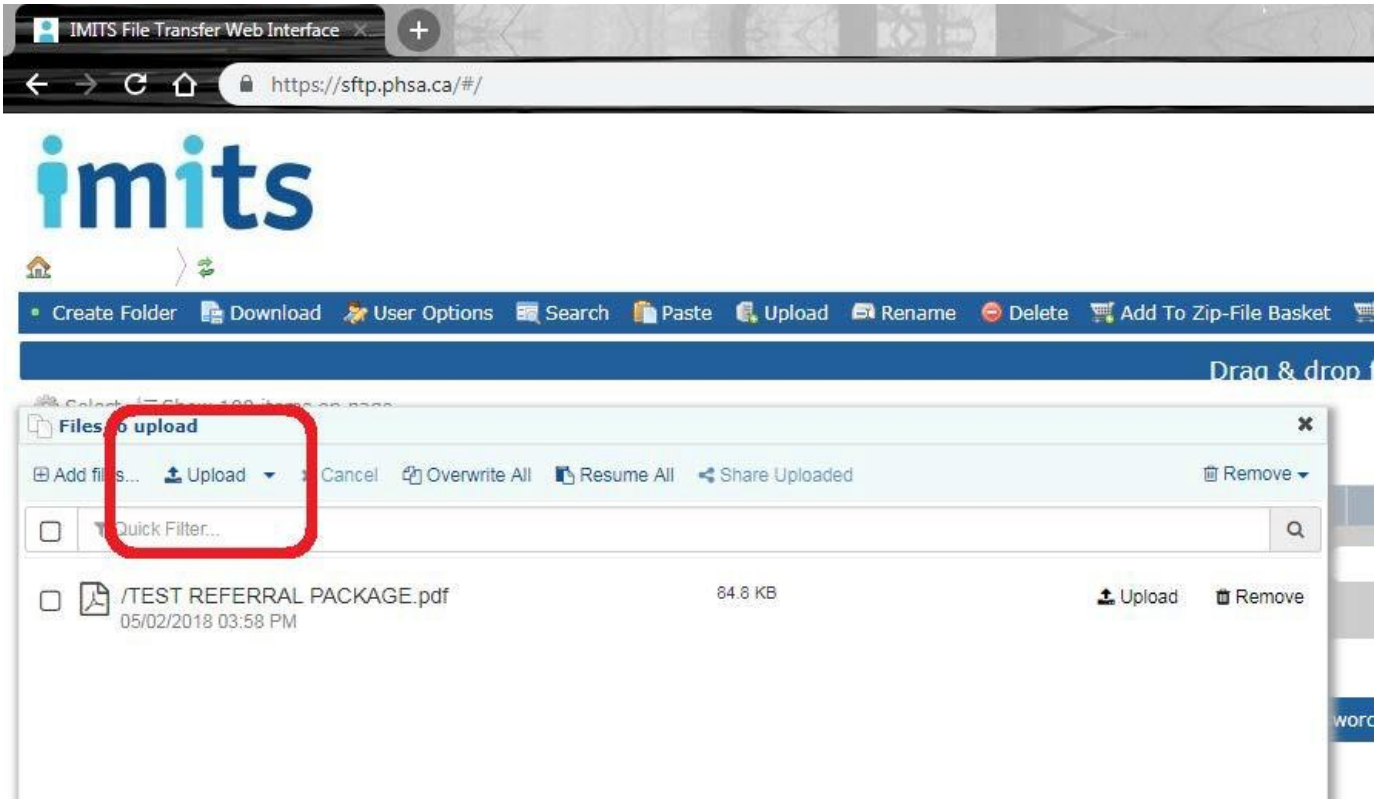
3. Upon logging in, you will be greeted with this screen.
To upload a referral to send to CAIT, click on "Add Files" in the left corner.



4. After clicking "Add Files", a new box will open up that will allow you to navigate to your saved referral document.
Select your referral and click "Open".



5. In order to complete the file upload, click on "Upload" in the new box.



Once the file has successfully been uploaded it will **Not** appear on the main screen and will have '**disappeared**'.
The file is now ready for CAIT to access and download.

6. To end your Secure File Transfer Protocol Session, simply close your browser window or tab.

BRITISH COLUMBIA | Ministry of Health

CARE FACILITY ADMISSION CONSENT

HLTH 3909 2019/09/23

This form is to be completed by the manager giving due consideration to Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFAA) and the Practice Guidelines for Seeking Consent to Care Facility Admission (Ministry of Health). Information is being collected under the authority of the HCCCFAA. A **manager** is defined by the HCCCFAA as an individual who is responsible for either or both of: (a) the operation of a care facility, or (b) admissions to a care facility.

INFORMATION OF ADULT TO BE ADMITTED

Last Name of Adult to be Admitted	First Name of Adult to be Admitted	Second Name(s)
Personal Health Number (PHN)	Birthdate (YYYY / MM / DD)	

Consent provided by (choose one)

☐ the adult to be admitted ☐ the substitute (adult determined to be incapable through assessment)

PROPOSED ADMISSION

It is proposed that the adult be admitted to the following facility:

Name of Care Facility	Address of Care Facility

CONSENT OF ADULT OR SUBSTITUTE DECISION MAKER

Adult or substitute providing consent to mark the appropriate boxes:

☐ I have been given information about this care facility, including the care that will be received, the services that will be available and the circumstances in which I (or the adult) may leave the care facility.

☐ I have been given the opportunity to ask questions about admission to this facility, its benefits and risks, and the options if admission is not accepted.

I understand:

☐ The care options available and possible outcomes.

☐ I have the right to give or refuse consent to admission to this care facility.

☐ I can revoke consent to admission to this care facility at any time.

☐ If care and accommodation is offered at this care facility and I accept, it will become my (or the adult's) home.

Additional Comments:

Consent to the above-named care facility was:

☐ provided in writing ☐ provided orally ☐ inferred from conduct - describe:

ADULT TO BE ADMITTED - WRITTEN CONSENT

☐ **I CONSENT to being admitted to the above-named care facility.**	Signature of Adult to be Admitted	Print Name of Adult to be Admitted
		Date Signed (YYYY / MM / DD)

OR: SUBSTITUTE DECISION MAKER - WRITTEN CONSENT

☐ **On behalf of the above-name adult, I CONSENT to the adult being admitted to the above-named care facility.**	Signature of Substitute Decision Maker	Relationship to Adult
	Print Substitute's Full Name	Date Signed (YYYY / MM / DD)

OR: MANAGER - CONSENT PROVIDED ORALLY OR INFERRED FROM CONDUCT

☐ **The above-named adult (or substitute decision maker on behalf of the adult) has CONSENTED to being admitted to the above-named care facility.**	Signature of Manager	Date Signed (YYYY / MM / DD)
	Print Name of Manager	Organization/Health Authority
	Name of Substitute Decision Maker	Relationship to Adult

PRINT CLEAR FORM

CENTRAL ADDICTION INTAKE REFERRAL PACKAGE BED BASED SUBSTANCE USE SERVICES (STLRs & Treatment)

Emerge, New Dawn, Together We Can & Pacifica Treatment Center

COVER SHEET

DATE: DD/MM/YYYY

Referral from: ☐ Vancouver Coastal/ Providence Health ☐ Fraser Health

Name of person making referral: Role:

Agency Name:

Agency Address:

Phone #: Email: Fax

How many sessions have you had with the client?

Will you continue to support your client through and after their stay at the STLR or Treatment Facility? Yes ☐ No ☐

REFERRING TO:

STABILIZATION & TRANSIONAL LIVING RESIDENCEs (STLRs):

☐ Emerge (men) ☐ Together We Can (men) ☐ New Dawn (women) ☐ Turning Point* (all genders)

TREATMENT CENTER: ☐ Pacifica (all genders)

CLIENT INFORMATION		
Legal Name:	**Date of Birth:** DD/ MM/ YYYY	**Age**
Preferred Name(s):	Personal Health Number (PHN):	
Street Address:		
City:	Province:	Postal Code:
Telephone:	Okay to leave a message? Yes ☐ No ☐	Email:
Emergency Contact: Name:	Phone:	
Relationship:		
Can we contact this person if you are discharged early from the STLR or Treatment Facility? Yes ☐ No ☐		

CHECKLIST : Before faxing the completed referral package make sure all document s are complete and included

☐ Care Facility Admission Consent

☐ Consent for Release of Information

☐ Complete referral assessment

☐ Discharge Care Plan

☐ MSDPR Funding Verification

QUESTIONS or GENERAL INQUIRIES

The Central Addictions Intake Team

Phone: 604-675-2455 Ext. 22564 for Pacifica, Together We Can

Phone: 604-675-2455 Ext. 22563 for Central City Lodge & New Dawn

Hours of Operation: 8:30am-4:30pm, Monday to Friday

CENTRAL ADDICTION INTAKE REFERRAL ASSESSMENT

"TIPS" for guidance only

ASSESSMENT for CLIENT NAME: _____ **REFERRAL DATE:** _____

Referral Reason & presenting situation:

Tip: Include details of the presenting situation and current functioning as described by the client, the referral source, family or others concerned.

History of presenting situation/History of presenting illness:

Tip: Include a description of the onset and development of the presenting problems, fluctuations in their severity and their impact on the individual's life and environment. Identify any collateral information as such.

Medical History:

Allergies and reaction: List current medical conditions. Are their current health conditions stable? Does the client require any special medical equipment or supplies, wound care?

TB Symptom screen: ☐ **None:** ☐ **Cough** ☐ **Productive cough** ☐ **Hemoptysis** ☐ **Night Sweats** ☐ **Fever** ☐ **Weight loss** ☐ **Chest pain** ☐ **Fatigue** ☐ **Other**

Medications:

Is the client currently taking their medications as prescribed?

Is the client prescribed opioid agonist therapy?

Is the client prescribed safe supply or any other narcotics?

Mental Health History:

List current psychiatric conditions. Are their mental health conditions stable? Do they have any serious challenges with their cognition/memory? Have they been hospitalized recently for a mental health condition?

Substance Use, Treatment and Supports: OR attach SU assessment

Tip: Include current SU hx past 30 days, SU goals, and past substance use treatments such as medications, withdrawal management, harm reduction, individual, group, peer supports, treatment programs, support recovery, cultural connection and specialized supports.

Personal & Social History:

Tip: Include personal history (family background and strengths) and current psychosocial factors (e.g. activities of daily living, housing, finances/income, education/work, community supports, cultural identity and spirituality, gender identity and expression, sexual orientation and relationship status).

Legal History:

Tip: Include current and past legal issues, involvement with law enforcement. Any court dates? Probation?

Mental Status:

Tip: Include appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perceptions (e.g. hallucinations), cognition (e.g. alertness, orientation, attention, concentration, visuospatial, language and executive functions), insight and judgment.

Risks:

Tip: Include risks related to substance use, overdose hx, and other risks (e.g. harm to others, self-harm, suicidality, harm by others, child protection, violence in relationships) and severity (e.g. current ideation, intent, plan, approximate dates of previous attempts, and information regarding lethality of attempts).

Assessment Summary and Treatment Recommendations

A synopsis of the main points from your assessment. Why is your recommended placement most suitable for this client? Please note any specific or unique needs the person may have during treatment.

Signature: of person making this referral

CENTRAL ADDICTION INTAKE REFERRAL ASSESSMENT
RESIDENTIAL SUBSTANCE USE SERVICES (STLRs & Treatment)

Emerge, New Dawn, Together We Can, & Pacifica Treatment Center

ASSESSMENT for CLIENT NAME: **REFERRAL DATE:**

Referral Reason & presenting situation:

History of presenting situation/History of presenting illness:

Physical and Medical History:

Medications:

Psychiatric History/Mental Health History:

Substance Use treatment and Supports:

Family Medical & psychiatric History

Personal & Social History:

Legal History:

Mental Status:

Risks:

Assessment Summary and Treatment Recommendations

Signature:

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ADDITIONAL FORMS for CAIT INTAKE REFERRALs

CONSENT FOR RELEASE OF INFORMATION

Please indicate below your consent for STLR or Treatment Facility and CAIT staff to share your personal information with the following individuals:

Name	**INVOLVEMENT** (e.g lawyer, PO, Family)	**TELEPHONE #** (include extensions)	**Limitations to the information you consent to share**

I, _____ (full name) consent to the release of information as specified above

Client Signature:

DATE:_____
DD/MM/YYYY

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CARE PLAN

CLIENTS NAME: **Referred By:**

A care plan will be initiated at the time of referral assessment, in collaboration with the client, family, community care team, bed-based SU service and CAIT. Care plans will be reviewed and updated when a bed becomes available, prior to admission where possible. Care plans are shared with clients, family, community care providers and SU service providers prior to admission and updated as needed during admission.

The community care team will document planning around the following care plan items in preparing the client's for their admission and support the client while waiting for their bed.

Name of bed-based program:

Estimate wait time:

Substance use stabilization (withdrawal management) required prior to admission:

Medication optimization, OAT titration plan prior to intake (no safe supply at the sites except for Fentanyl Patch/es):

Prescriptions required for admission:

Shelter:

Income:

Community supports/OOT:

Harm reduction:

Family/social supports:

Safety (aggression, falls risk):

Transportation plan to support client to arrive for intake:

Additional considerations:

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DISCHARGE CARE PLAN

Instructions:

- Must be completed prior to admission, updated as needed and verified with the client on discharge.
- A discharge prescription must be requested either from the client's community prescriber, the site's physician or START prior to discharge. Ensure a photo copy of the prescription is in the client file.
- In case of sudden, unplanned discharge, where the clients' community prescriber is unavailable, contact START/CAIT urgently by phone to support with OAT prescriptions, ideally before the client has left the service. START/CAIT will follow up with the client urgently in the community.
- For all discharges, send the discharge care plan to CAIT through IMITS and START/CAIT will follow up with the client and their community care providers.
- Provide the client with a discharge prescription and copy of their discharge care plan when they leave.

Complete this Section Prior to Intake, STLR or Treatment Staff Review and Update with Client on Discharge

Client Name: _____ Birthdate: _____
Client Phone or Alternative Contact Method: _____
Emergency Contact name: _____relationship:_____number:_____
Consent to notify emergency contact in case of unplanned discharge:
Community Primary Care Provider or OOT:
Other Family/Social Supports (if different from emergency contact):
Family/Social Support that can provide a safe place to stay or plan for housing/shelter if needed:
Transportation plan to discharge destination:
Pharmacy Name and Location (to fax discharge prescription/s):
Referring Team/Care Provider Contact:

STLR or Treatment Site Staff Complete this Section at the Time of Discharge:

Discharge Destination: _____
Discharge Reason: ☐ Planned Discharge ☐ Unplanned Discharge ☐Client Initiated☐Staff Initiated
☐Unable to verify/locate client
☐Emergency contact notified
☐ Referring Team/Care Provider notified
☐Discharge Care Plan Updated/complete
☐Site pharmacy notified
☐Prescriptions provided on discharge ☐Naloxone Kit provided
☐ Notify **CAIT** weekdays **604-675-2455 ext. 22564 or 22563** and **START 604-658-1278** on the weekend urgently by phone in case of unplanned discharge (teams will follow up 830-1630 7 days/week).
☐Send competed discharge care plan to CAIT/START via IMITS

Discharge Date: _____ Discharge Time: _____ Staff Signature:_____

Client Discharge Instructions: In case of unplanned discharge, the VCH START/CAIT team will reach out to you to ensure ongoing connection to care in the community and support with any concerns you may have, access to medications including Opioid Agonist Therapy. You may also contact the VCH CAIT team 7 days/week 8:30 am-4:30 pm @ **604-675-2455 ext. 22564 or 22563** and/or visit the Rapid Access Addiction Clinic at St. Paul's Hospital 7 days/week 9:00 am-4:00 pm.

All Forms to be completed and sent with all CAIT intake referrals via IMITS

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MSDPR FUNDING VERIFICATION

Referring Agent: Please complete and return to CAIT via IMITS

Ministry Agent: Please complete and return to CAIT via Email

CLIENT NAME:		**DATE of Completion:**	DD	/	MM	/	YYYY
S.I.N:		**D.O.B.**	DD	/	MM	/	YYYY

This person has been referred for admission to: Name of residential addictions program.

Prior to admission, we require confirmation that the client's per diem costs (less any non-exempt income) will be paid by MSDPR while in receipt of, and eligible for, income assistance. Once the client has been admitted the facility will send an admission report.

Income from Other Sources	**$**		**Source**	
Income from Other Sources	**$**		**Source**	

Client Authorization	I, **……..,** authorize the Ministry of Social Development & Poverty Reduction to confirm my eligibility for funding, and to release any related information to the staff of Vancouver Coastal Health CAIT program and the above named residential/support recovery addictions program. _____ **Date:**_____ Client Signature DD/MM/YYYY

Ministry of Social Development & Poverty Reduction - *COMPLETE & SEND BACK THE SAME DAY*

☐ Client has an open and active file ☐ Client eligibility yet to be determined ☐ Client file has been closed ☐ Client is eligible for funding as follows:	***Comments:***

	MSDPR will pay Client's monthly per diem as per current eligibility less any non-exempt income from other sources as follows:				
	Client Contribution:	(non-exempt income)	$		
	Non-exempt income from				
	Maximum Amount Payable by MSDPR Per Month		$		

MSDPR Contact Name:		*Place Office Stamp Here*
Telephone contact:		
Date:		

All Forms to be completed and sent with all CAIT intake referrals via IMITS