LCSS

LANGLEY INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL

FAX ALL REFERRALS TO 604-514-1419

Please ensure the form is complete with all relevant information.

REFERRAL SOURCE : Agency, program or person referring those to receive services

Person Completing Referral: _____ Referral Date: _____

Referral Source: _____ Role: _____ Phone: _____
(i.e.: Self, Program, Site)

Email: _____ Is applicant aware of referral: ❑ Yes ❑ No

PARTICIPANT INFORMATION: Person receiving services

First Name: _____ Middle Name: _____

Last Name: _____ Alias/Preferred Name: _____

PHN #: _____ Birthdate: _____ Highest Education: _____

Gender: _____ Gender Pronoun: _____ Family Status: Single ❑ Couple ❑ Family ❑

Ethnicity/Race: _____ ❑ Declined to Answer

Indigenous Identity: ❑ First Nation Status ❑ First Nation Non-Status ❑ Métis ❑ Inuit ❑ Non-Indigenous

Identifying Features (Height, Hair Color, Tattoos etc.): _____

_____

Phone: _____ E-mail: _____

Current Address: _____ No Fixed Address: ❑
(Street) (City / Town) (Postal Code)

Best place(s) to locate: _____

Describe your current living situation: _____

_____

❑ Never Have a Place to Stay ❑ Sometimes Have a Place to Stay ❑ At Risk of Losing Housing ❑ Stable Housing

SOURCE OF INCOME:

❑ Employment	❑ Workers Compensation Board (WCB)
❑ Employment Insurance (EI)	❑ Union Disability
❑ Income Assistance (IA)	❑ Private Pension
❑ Persons with Persistent Multiple Barriers (PPMB)	❑ Canada Pension Plan (CPP) / Old Age Security (OAS)
❑ Persons with Disabilities (PWD)	❑ Public Guardian and Trustee (PGT)
❑ No Income Source	❑ Other: _____

If employed, please describe: _____

LCSS

LANGLEY INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL

FAX ALL REFERRALS TO 604-514-1419

PARTICIPANT MEDICAL INFORMATION:

Describe any medical or physical concerns, diagnosis or disabilities that you are currently experiencing: _____

_____

_____

_____

_____

_____

_____

_____

Check all that apply:

- ❑ Hepatitis C
- ❑ HIV
- ❑ Developmental Disability
- ❑ Acquired Brain Injury

Allergies: _____

General Practitioner First & Last Name: _____ ❑ GP or ❑ NP

Phone: _____ Fax: _____

Medication Information: (Please list ALL medications and supplements you take)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication Coverage: ❑ No Coverage ❑ Medical Services Plan (MSP) ❑ Other: _____

If available, attach current: ❑ Prescription(s) and/or ❑ Medication Administration Record (MAR)

LCSS

LANGLEY INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL

FAX ALL REFERRALS TO 604-514-1419

PARTICIPANT MENTAL HEALTH & SUBSTANCE USE INFORMATION:

MENTAL HEALTH INFORMATION:

Check all that apply

- ❑ Depression
- ❑ Anxiety
- ❑ Substance Induced Psychosis
- ❑ Other: _____
- ❑ Bipolar
- ❑ Schizophrenia
- ❑ ADHD
- ❑ Psychosis

Describe any mental health concerns you are currently experiencing:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Risk of Self-Harm and/or Suicide:

❑ Current ❑ Historical ❑ No History

Please describe:

_____

_____

_____

_____

Risk of Harm to Others:

❑ Current ❑ Historical ❑ No History

Please describe:

_____

_____

_____

Psychiatrist: _____ Phone: _____

Counsellor/Therapist: _____ Phone :_____

Have you spent any time in hospital for mental health or substance use in the past 12 months?: ❑ Yes ❑ No

If yes, please describe: _____

Extended Leave upon Discharge: ❑ Yes ❑ No Mental Health Act Certificate Expiry Date: _____

Details: _____

_____

LCSS

LANGLEY INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL

FAX ALL REFERRALS TO 604-514-1419

SUBSTANCE USE INFORMATION:

Do you have any ongoing or dependent substance use:

❑ Yes ❑ No *If yes:* How long? _____

Please indicate primary and secondary substance use

Substance(s) of choice:	Primary	Secondary
❑ Opiates / Fentanyl	❑	❑
❑ Methamphetamines	❑	❑
❑ Cocaine	❑	❑
❑ Cannabis	❑	❑
❑ Alcohol	❑	❑
❑ Other: _____	❑	❑

Are you currently engaged in Substance Use Services: ❑ Yes ❑ No

If yes: Check all that apply:

❑ Suboxone
❑ Methadone
❑ Kadian
❑ Sublocade
❑ iOAT (Injectable Opioid Agonist Treatment)
❑ Other: _____

OAT Dr: _____

OAT Clinic: _____

Do you inject drugs? ❑ Yes ❑ No

Have you ever shared needles? ❑ Yes ❑ No

If yes: How long? _____

History of Overdose: ❑ Yes ❑ No

If yes: How many? _____

Date of Most Recent Overdose: _____

Do you have a safety plan when using substances?: ❑ Yes ❑ No

If yes: Please describe: _____

_____

_____

_____

_____

_____

_____

PARTICIPANT FORENSIC HISTORY (if applicable):

Current Criminal Charges: _____

_____

Upcoming Court Date (if applicable): _____

Past Criminal Charges: _____

_____

Forensic Case Manager Name: _____ Phone: _____

Probation Officer Name: _____ Phone: _____

LANGLEY INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL

FAX ALL REFERRALS TO 604-514-1419

PARTICIPANT SUPPORT NEEDS:

What support(s) are you interested in:

- ❑ Substance Use or Addiction Services
- ❑ Employment / Volunteer
- ❑ Physical Health
- ❑ Counselling
- ❑ Mental Health / Psychiatric Services
- ❑ Housing / Maintenance
- ❑ Basic Life Skills
- ❑ Identification
- ❑ Cultural / Spiritual Support
- ❑ Harm Reduction Supplies
- ❑ Naloxone Training / Kit
- ❑ Financial (Specify : _____)
- ❑ Advocacy (Specify: _____)

Please explain what services you are interested in and how the Intensive Case Management Team can best help you:

_____

_____

_____

_____

_____

PROGRAM PARTICIPATION

I understand that Intensive Case Management is a voluntary service. I am interested in participating in the program and if accepted, I agree to meet with Intensive Case Management staff a minimum of once per week to work on goals I identify for myself.

Client Signature:_____ Date:_____

EMERGENCY CONTACT INFORMATION:

Emergency Contact First & Last Name: _____

Phone: _____ Relationship:_____

I, _____ give permission for the Intensive Case Management team to contact my Emergency Contact for the purpose of locating me.

Client Signature:_____ Date:_____

Witness:_____ Date:_____

Please Note: A referral does not guarantee acceptance to Intensive Case Management Services.
All referrals will be followed up on by an Intensive Case Management team member.