fraserhealth Better health. Best in health care. | First Nations Health Authority Health through wellness | Lookout | raincity HOUSING | LCSS Langley Community Services Society | BC HOUSING

INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL

FAX TO:

SURREY CLINICAL: 604.585.5625	CHILLIWACK: 604-528-5415	ABBOTSFORD/MISSION: 604-851-4826
SURREY PEER: 778-825-1046	LANGLEY: 604-514-1419	MAPLE RIDGE: 604-380-1172

Please ensure the form is complete with all relevant information.

REFERRAL SOURCE : Agency, program or person referring for services, can be self

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

DO YOU HAVE AN INCOME SOURCE:	
❑ 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: ____

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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 ❑ Sublocade
❑ Methadone ❑ iOAT (Injectable Opioid Agonist Treatment)
❑ Kadian ❑ 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: ____________________

____

____

HEALTH 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

❑ FAS/FASD

Allergies: ______________________________________

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

Phone: ________________________ Fax: ________________________

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

____

____

What is your primary pharmacy (if you have one)

____

Please detail if you have daily dispense or pick up

____

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

Do you have other community supports: (CLBC, Connective, Support Workers, Case Manager, Outreach)

____

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: ____

____

Do you have current criminal charges or involvement with the court system we should be aware of: ____________________

____

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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.

Referral Outcome:

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ICM ELIGIBILITY CRITERIA
Client is **19** years of age or older.
Problematic or Chronic Substance Use
Significant functional challenges associated with **Housing.**
Significant functional challenges associated with **Income.**
Significant functional challenges associated with **Physical Health.**
Difficulties accessing **health** services and/or not well served by traditional models of mental health and substance use.
Difficulties accessing **social** services and/or not well served by traditional models of mental health and substance use.