INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL

FAX TO:

SURREY CLINICAL: 604.585.5625 | CHILLIWACK: 604-528-5415 | ABBOTSFORD/MISSION: 604-853-0291
SURREY PEER: 778-825-1046 | LANGLEY: 604-514-1419 | MAPLE RIDGE: 604-380-1172

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.

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: _____

_____

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 (ICM) is a voluntary service. I give permission for the ICM team under the authority of section 26 (c) of the **Freedom of Information and Protection of Privacy Act (FIPPA)** for the purposes of assessing and determining eligibility for ICM team or other appropriate existing Mental Health and Substance Use Programs.

This may include but is not limited to, outreach workers, shelters, hospitals, and police services. The purpose of this contact is solely to support engagement and connected to services, not for enforcement or legal action.

I also give permission for the ICM team to review my health care history and any other relevant collateral information that may support assessment and service planning. This may include information from health care providers, social service agencies, housing providers, and law enforcement, where appropriate.

All information will be accessed and used only as necessary to determine eligibility and to support my care. Information sharing with comply with applicable privacy laws and ethical standards. I understand that I may withdraw this consent at any time.

Client Signature:_____ Date:_____

OPTIONAL

❑ I choose to have the following community partners or agencies excluded from the above signed consent (please list):

_____ _____ _____

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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Client Feedback on consent Form

Please rate the following statements about the consent form using the scale below:
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

1. The consent form clearly explained the purpose and use of my information.

[1] [2] [3] [4] [5]

2. The language used in the consent form was easy to understand.

[1] [2] [3] [4] [5]

3. The consent form provided the right amount of detail.

[1] [2] [3] [4] [5]

Optional: What could we improve about the consent form?

_____
_____
_____
_____