WESTMINSTER HOUSE

PLEASE PRINT THIS FORM AND FAX THE COMPLETED COPY TO 604-524-4634

REFERRING AGENTS PLEASE NOTE:

Clients must have their name on the waitlist **before** we can accept a completed referral package from an agent.

A referral received without client on the waitlist will be held for 48 hours only. Clients applying for MHSD must complete the release of information included in this document.

INTAKE OFFICE:

Toll Free: 1-866-524-5633

Office: 604-524-5633

Fax: 604-524-4634

Email: info@westminsterhouse.ca

Address: 228 Seventh Street, New Westminster, BC V3M 3K3

Once a client has been placed on the wait list, in order to maintain their position on the list the client must:

- Call everyday to check in with any Westminster House Staff. All check-ins are documented. If I client does not call in within a 2 weeks period they will be taken off the wait list.
- Funding confirmation in place
- Confirmation of TB testing
- Clients referral package filled out by a counsellor, Doctor, or Social Worker
    - Print the referral package
    - Fill out the referral package in detail
    - Sign the referral package
    - Fax the completed document to 604-524-4634
    - All referral sources are considered

DAILY SCHEDULE

6:30 AM	-	Wake, make bed, dress	5:15 PM	-	Dinner
7:00 AM	-	Breakfast	Evening	-	12 Step Meeting
7:40 AM	-	Leave for 12 step meeting	10:00 PM	-	Curfew
10:00 AM	-	Group	10:30 PM	-	Bed Time
12:15 PM	-	Lunch	11:00 PM	-	Lights Out
Afternoon	-	Planned Activities			

WESTMINSTER HOUSE REFERRAL FORM

The referral form information will be used to determine the client's suitability to the program. To make sure this client gets the best outcome from treatment, please complete the form as thorough as possible.

REFERRING AGENCY INFORMATION

Date _____

Referring Agent _____

Agency Address _____

City _____ Postal Code _____

Phone _____ Fax _____

Email _____

Do you want contact with this client while in treatment at W'House? Yes ☐ No ☐

If yes, how often do you wish to check in with this client? _____

CLIENT INFORMATION

Is the client aware this is a non-smoking program? Yes ☐ No ☐

Name _____

Address _____

City _____ Postal Code _____

Phone _____ Other _____

Email _____ DOB _____

SIN _____ Medical # _____

Marital Status _____ Employment _____

Physician _____ Phone _____

Next of Kin _____ Phone _____

Are your immunizations up to date? Yes ☐ No ☐

Do you have a record of your immunizations? Yes ☐ No ☐

MEDICAL

Does the client have any special health care needs? Yes ☐ No ☐

If yes, explain :

Is the client on any prescribed medications? Yes ☐ No ☐

Current Medications (attach MAR sheet where applicable):

Has the client been diagnosed with an eating disorders? Yes ☐ No ☐

If yes, explain :

Does the client have any allergies? Yes ☐ No ☐

If yes, explain :

Does the client have any Physical Limitations? Yes ☐ No ☐

If yes, explain :

FINANCIAL STATUS

How will treatment be financed? _____

Name _____ Phone _____

Name _____ Phone _____

SUBSTANCE ABUSE HISTORY

SUBSTANCE	DURATION (YRS/MTHS)	LAST USE
1.)		
2.)		
3.)		
4.)		
5.)		
6.)		

Other addictions of concern: (ie: gambling, shopping)

PSYCHIATRIC HISTORY

Is the client currently mentally stable? (ie: recent hospitalizations).

If NOT, explain:

Does the client have a history of treatment for mental health issues? (ie: therapist, counsellors, psychiatrist, psychologist)?

If yes, explain:

Is the client taking any medications related to psychiatric/mental health issues? (attach MAR sheet where necessary)

If yes, explain:

LEGAL STATUS

Is the client on probation or parole?

If yes, explain:

Does the client have any pending charges/court appearances?

If yes, explain:

SOCIAL HISTORY

Please write a brief history of the client's involvement with family, friends and significant others.

REFERING AGENT ASSESSMENT OF CLIENT

Please provide a brief statement about the client's strengths, goals, and perceived situation. What makes you think this client is suitable for a residential program?

EARLY EXIT TRANSITON PLAN

The following will be put into place if the client is discharged on short notice, either ACA (against clinical advice) or for non-compliance:

Community/Health Authority:

Name of destination upon early exit:

Address of destination upon early exit:

Community Contact for early exit support: Phone:

Shelter: Yes ☐ No ☐ Residence: Yes ☐ No ☐

Comments:

Other Supportive Housing:

Emergency Contact (this person will be contacted upon unsupported discharge) Phone:

Not done yet, see next page for HoNOS survey.

HEALTH OF THE NATION OUTCOME SCALES (HONOS) - ADULT

- **Rate** each scale in order from 1 to 12
- **Do not** include information rated in an earlier item except for item 10 which is an overall rating
- **Rate** the MOST SEVERE problem that occurred during the period rated
- **All scales** follow the format:

    0 = no problem

    1 = minor problem requiring no action

    2 = mild problem but definitely present

    3 = moderately severe problem

    4 = severe to very severe problem

	Rate 9 if unknown	
1. Overactive, aggressive, disruptive or agitated behaviour	0 1 2 3 4	
2. Non-accidental self-injury	0 1 2 3 4	
3. Problem-drinking or drug-taking	0 1 2 3 4	
4. Cognitive problems	0 1 2 3 4	
5. Physical illness or disability problems	0 1 2 3 4	
6. Problems associated with hallucinations and delusions	0 1 2 3 4	
7. Problems with depressed mood	0 1 2 3 4	
8. Other mental and behavioural problems	0 1 2 3 4	
9. Problems with relationships	0 1 2 3 4	
10. Problems with activities of daily living	0 1 2 3 4	
11. Problems with living conditions	0 1 2 3 4	
12. Problems with occupation and activities	0 1 2 3 4	

RELEASE OF INFORMATION

WHEN SIGNING THIS FORM PLEASE INFORM YOUR CLIENT THEY ARE CONSENTING TO THE RELEASE OF INFORMATION TO YOU, THE REFERRAL AGENT, AND THE FUNDING AGENT (WHERE NECESSARY), REGARDING THEIR RELATIONSHIP WITH WESTMINSTER HOUSE AND THEIR PROCESS OF ADMISSION.

Your attention to this referral form is greatly appreciated and we thank you in advance for your co-operation in taking the time to fill it out. It will assist our team in addressing the particular needs of each of our clients. If you have any questions; please contact our staff at 604-524-5633 or 866-524-5633 Fax: 604-524-4634.

Referral Agent Name: _____ Phone: _____

Referring Agent Signature: _____

Client Name: _____

Client Signature _____

Note: Funding agency must be filled by completed (only) when funded by public funding sources such as MHSD.

Clint Name _____

Client S.I.N _____

Funding Agency: _____

MSP – PREMIUM ASSISTANCE APPLICATION

All Westminster House clients must complete the application from premium assistance.

http://www2.gov.bc.ca/assets/gov/health/forms/119fil.pdf

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