

Youth Detox and Supportive Residential Referral Form

Program Requested (tick all that apply)

- 180 –JHSNI phone: 250-286-0611, fax: 250-286-3650
- Boys and Girls Club phone: 250-370-5925, fax: 250-370-5951
- Transitions -NARSF phone: 250-714-8167, fax: 250-754-1605
- Specialized Youth Detox - YES phone: 250-383-3514, fax: 250-383-3812

Service Requested

- Detox (7-10 days)
- Supportive Residential (up to 3 months)
- Both

Date of Referral: _____
Day/Month/Year

Referral Source Name: _____ Office: _____

Phone: _____ Fax: _____ Email: _____

Youth Information:

Name: _____ DOB: _____

Age: _____ Care Card #: _____

Male: _____ Female: _____ Transgender/Other: _____ Aboriginal: _____

Current Address: _____

Postal Code: _____ Email: _____ Phone: _____ Cell: _____

Parent/Guardian: _____ Relationship: _____ Phone: _____

Social Worker: _____ Phone: _____ Fax: _____

Other Professionals: _____ Phone: _____ Fax: _____

Related Issues/Risk Factors

<input type="radio"/> Mental Health Issues/FAS	<input type="radio"/> Language Barriers	<input type="radio"/> Eating Disorders
<input type="radio"/> Homelessness/Couch Surfing	<input type="radio"/> Not in School	<input type="radio"/> Suicide
<input type="radio"/> Criminal Behavior	<input type="radio"/> Self Harm/Cutting	<input type="radio"/> Physical Disabilities
<input type="radio"/> Youth Justice Involvement	<input type="radio"/> Disconnected from Family	<input type="radio"/> Pregnant
<input type="radio"/> History of Fire Setting	<input type="radio"/> Aggressive Behaviours	<input type="radio"/> Medical Conditions

Is the youth aware of this referral? Yes _____ No _____

Does the youth agree to the referral? Yes _____ No _____

Substance Use History

Intent: To understand their substance use history in order to assess the impact of their use.

The following were used at least once (for non-medicinal purposes):

SUBSTANCE & RANK ORDER (ONLY #1, 2, &3)	Age of 1 st use	# of Days Used in Past 30 Days?	Current Use (Y/N)	Pattern	Quantity	Method	SOC*
Tobacco <i>(do not rank)</i>							
Alcohol							
Cannabis							
Ecstasy							
Cocaine							
Crack Cocaine							
Hallucinogens							
Crystal Meth							
Heroin							
Inhalants							
Prescription							
Methadone							
Steroids							
Over the counter							
Other							

Additional Comments: Please identify client strengths/resiliencies that will assist youth to be successful in the program. (Please attach YFAS assessment if completed)

Strengths:

Challenges:
