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| **TRANSITIONS PROGRAM REFERRAL** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Service Requested:  Withdrawal Management (7-10 days)  Supportive Recovery (up to 3 months) | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Referred by: | | | | |  | | | | | | | | | | | | Date of Referral: | | | | | | |  | | |
| Team/Org/Agency or Self: | | | | | | |  | | | | | | | | | |  | | | | | | | (dd/mm/yy) | | |
| Phone: |  | | | | | | | Fax: |  | | | | | | | Email: | | |  | | | | | | | |
| **1. Youth & Family Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Youth Name: | | | | | |  | | | | | | | | Birth Date: | | | | | | | |  | | | Age: |  |
| Gender: | | | F M Non-Binary Other: | | | | | | | |  | | | | | | PHN: | | | | | (dd/mm/yy) | | |  | |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Main Phone: | | | | |  | | | | | | | | Alt. Phone: | | | | | | |  | | | | | | |
| Caregiver: | | | |  | | | | | | | | | | | Relationship: | | | | | | | |  | | | |
| Phone: | |  | | | | | | | | | | | Email: | | | | |  | | | | | | | | |
| **2. Other Professionals Involved:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | Role/Relationship: | | | | | | | | | | | Phone/Fax: | | | | | |
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|  | | | | | | | | | |  | | | | | | | | | | |  | | | | | |
| **3. Substance Use:** Please describe past or current substance use. Current substance use? Y N | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| --- | --- | --- | --- | --- | --- | --- | --- |
| **4. Presenting Concerns:** | | | Please identify client strengths/resiliencies that will assist with success in the program. | | | | |
|  | | | **i.** | | | | |
| **ii.** | | | | |
| **iii.** | | | | |
| **5. Risk Factors & Safety Concerns:** | | | | | | | |
| Mental health considerations  Suicidal ideations  Self-harm Significant medical needs  Legal issues  Violence/aggression  AWOL/flight risk | If present, please describe: | | | | | | |
| If risk factors are present, is there a safety plan? Y  N | | | | | | |
| Follow up date: |  | | Staff: | |  | |
|  | (dd/mm/yy) | |  | |  | |
| **6. Additional Information:**  Please detail any additional information that may impact the referral, if applicable. | | | | | | | |
|  | | | | | | | |
| **7. Verification & Consent:** Please ensure the referral is complete, correct and that the person referred is aware of the referral, and if possible, has provided consent. | | | | | | | |
| Consent for referral provided by person(s) being referred: Y N | | | | | | | |
|  | | | | | Date: | |  |
| Signature of person(s) being referred or indicate verbal consent | | | | |  | | dd/mm/yy |
|  | | | | | Date: | |  |
| Signature of referring person | | | | |  | | dd/mm/yy |
| Please fax signed and completed referrals to: 250-754-1605 Please do not email. | | | | | | | |