Transition Unit Referral Form

Treatment Service:

☐ Day-Program ☐ Residential Program

Referral Date:

CLIENT INFORMATION

Client Name: Pronouns:

PHN: DOB (mm/dd/yy): Age:

Address:

Phone Number: Can we leave an identifying message? ☐ Yes ☐No

Email Address:

Emergency Contact Name & Phone Number:

REFERRAL SOURCE INFORMATION

Referring Agency: Referring Source Name:

Phone Number: Email Address:

CURRENT SUPPORTS

☐ Community Mental Health ☐ Addiction Counsellor (Last Appointment: _____)

☐ Psychiatry ☐ Probation Services

☐ CCRB ☐ Child Protection (Is the file open? ☐ Yes ☐ No)

☐ Community Groups (NA/AA/GA) ☐ Housing First/Outreach ☐ Family Support

Additional Information:

BASED ON YOUR KNOWLEDGE, WHAT STAGE OF CHANGE BEST DESCRIBES THE CLIENT'S CURRENT OUTLOOK ON RECOVERY?

☐ Precontemplation ☐ Contemplation ☐ Preparation ☐ Action

DOES THE CLIENT HAVE A DIAGNOSED MENTAL HEALTH DISORDER? ☐ YES ☐ NO

If yes, please explain:

How severely is this affecting client's functioning? (i.e., interpersonal interactions, ability to function in a group environment, level of insight, independence, etc.)

☐ Minimal ☐ Moderate ☐ Moderate-Severe ☐ Severe

ARE THERE ANY BARRIERS THAT MAY AFFECT THE CLIENT'S ABILITY TO PARTICIPATE IN PROGRAMMING?

☐ Primary caregiver for dependent(s) ☐ Non-compliant with prescribed medication(s)

☐ Employment ☐ Mobility ☐ Transportation

☐ Maintaining home/apartment ☐ Learning Challenges ☐ Literacy Level

☐ Language ☐ Other:

If there are any identified barriers, please provide additional details:

CLIENT LEGAL INFORMATION

Does the client have pending legal charges? ☐ Yes ☐ No

Is the client on probation? ☐ Yes ☐ No Is the client on parole? ☐ Yes ☐ No

Are there any Emergency Protection Orders, no-contact, stay away orders, etc. involved? ☐Yes ☐ No

If yes to any of the above questions, please provide additional details:

TO BE COMPLETED IN COLLABORATION WITH THE CLIENT:

Have you previously stayed on the Transition Unit? ☐ Yes ☐ No

If yes, what was the date of your previous involvement?

Are you currently on Opioid Replacement Therapy (ORT)? ☐ Yes ☐ No

What is your current length of abstinence and/or length of significant abstinence in the past?

If you struggle with a mental health disorder, please explain how you have been coping/managing to date:

Please provide details about your current problem behaviours and use, including, substances, gambling, and sex/pornography:

Problem Behaviour:	Amount & Frequency of Use:

Please answer the following questions using the Readiness Ruler below:

On a scale of 0 to 10, how **IMPORTANT** is it right now for you to change?

1	2	3	4	5	6	7	8	9	10

Not at all Important — Extremely Important

On a scale of 0 to 10, how **CONFIDENT** are you that you could make this change?

1	2	3	4	5	6	7	8	9	10

Not at all Important — Extremely Important

PERSONAL STATEMENT (TO BE COMPLETED BY THE CLIENT)

Why are you choosing to participate in the Transition Unit Program now?

How do you envision yourself at the time of discharge? What goals do you hope to have achieved by this time?

Client Signature: Date:

Referring Source Signature: Date: