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JohnHoward
The John Howard Society of North Island

REFERRAL

180° YOUTH DETOX AND SUPPORTIVE RECOVERY

REFERRAL INFORMATION

Date of Referral (D/M/Y) ☐

Referral Source Name ☐ Phone ☐

Referral Source Office ☐ Fax ☐

YOUTH INFORMATION

Name ☐ DOB (D/M/Y) ☐ Gender M ☐ F ☐ TG ☐ NB ☐

Care Card # ☐ Aboriginal Y ☐ N ☐ Band/Nation ☐

Current Address ☐ Phone ☐
Street City Postal Code

Parent/Guardian ☐ Relationship ☐

Current Address ☐ Phone ☐
Street City Postal Code

Social Worker ☐ Ph ☐ Fax ☐

Other Professional ☐ Ph ☐ Fax ☐

RELATED ISSUES/RISK FACTORS

☐ Mental Health Issues/FAS	☐ Language Barriers	☐ Eating Disorders
☐ Homeless/Couch Surfing	☐ Not Attending School	☐ Suicide Attempt/Ideation
☐ Criminal Behaviour	☐ Self-Harm/Cutting	☐ Physical Disability
☐ Youth Justice Involvement	☐ Disconnection from Family	☐ Pregnant

Is the youth aware of this referral? Y ☐ N ☐ Does youth want to detox (7-10 days)? Y ☐ N ☐

Does the youth agree to the referral? Y ☐ N ☐ Does youth want Stabilization (up to 6 months)? Y ☐ N ☐

ADDITIONAL COMMENTS

SUBSTANCE USE HISTORY

The intent is 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 and Rank Order (only # 1, 2, 3)	Age of 1st use	# of days used in past 30 days	Current Use Y	Current Use N	Pattern	Quantity	Method	Stage of Change
Tobacco (do not rank)			☐	☐				
Alcohol			☐	☐				
Cannabis			☐	☐				
Ecstasy			☐	☐				
Cocaine			☐	☐				
Crack Cocaine			☐	☐				
Hallucinogens			☐	☐				
Crystal Meth			☐	☐				
Heroin			☐	☐				
Inhalants			☐	☐				
Prescriptions			☐	☐				
Methadone			☐	☐				
Steroids			☐	☐				
Over the Counter			☐	☐				
Other			☐	☐				

Drug that causes most problems in your life:

ADDITIONAL COMMENTS

Please identify client strengths/resiliencies that will assist youth to be successful in the program.
(Attach YFAS assessment, if completed.)

Strengths:

Challenges:

END OF SECTION - PLEASE LEAVE REMAINING PAGES BLANK

Intake and Initial Assessment

180° YOUTH DETOX AND SUPPORTIVE RECOVERY

REMAINDER OF FORM WILL BE COMPLETED BY 180° PROGRAM STAFF

Name _____ Date _____

Hair Colour _____ Eye Colour _____ Height _____ Weight _____

Distinguishing Features _____

Family Doctor _____ Ph. _____ Last time you saw a doctor? _____

Emergency Contact

Name _____ Phone Numbers _____

School

Attending school? Y ☐ N ☐ Grade _____ School _____

Favourite Subjects _____

Learning Challenges? Y ☐ N ☐ Info unavailable ☐ Literacy Level _____ Info unavailable ☐

Employment

Currently working? Y ☐ N ☐ Where? _____

Describe some of your work history _____

Do you want employment while in the program? Y ☐ N ☐ Do you have a current resume? Y ☐ N ☐

Presenting Issues

Use your counselling skills to engage the referral agent or client in a conversation about the impact of issues on the client's life.

Are you here for yourself? Y ☐ N ☐ Or are you concerned about someone else? Y ☐ N ☐

Are you here because someone wants you to be? Y ☐ N ☐ Who? _____

What are some of the concerns or issues that have brought you here?

What made you look for support at this time?

What are you doing now that is helping you to manage the situation?

What are you hoping to get out of this program?

Who do you want to support you in your changes?

Immediate Risks

8. Do you have any current or historical medical concerns? (e.g., asthma, allergies, seizures) Y ☐ N ☐

Describe:

Prenatal Exposure? Y ☐ N ☐ Unknown ☐

9. Developmental milestones met? Information unavailable ☐

Eye sight? Hearing? Speech? Language function?

10. Are your immunizations up to date? Y ☐ N ☐ Unknown ☐

Describe:

11. Could you be pregnant? Y ☐ N ☐ Unknown Are you a parent? Y ☐ N ☐ Actively parenting? Y ☐ N ☐

12. Have you been diagnosed with a mental health concern? Y ☐ N ☐ Unknown ☐

By whom? Indicate Primary Diagnosis:

Are you on any Psychotropic Medication? Y ☐ N ☐ *(See medication info sheet.)*

Any other challenges such as FASD or Developmental or Neurological Disability? Y ☐ N ☐ Unknown ☐

Describe:

Do you want to work on your mental health issues? Y ☐ N ☐ Undecided ☐ Later ☐

13. Do you personally have any concerns about your emotional and mental health? Y ☐ N ☐

Additional information:

14. Are you thinking about suicide? ***If yes, complete suicide assessment with client immediately.*** Y ☐ N ☐

15. Are you thinking of hurting someone else? ***If yes, find out more details immediately.*** Y ☐ N ☐

16. Are there any additional immediate risks to self or others? (e.g., not taking meds, trouble with others, self-harm, animal cruelty)

Additional information:

17. Are you currently taking any prescription drugs? *(See medication sheet if yes.)* ☐ N ☐

18. Are you in a stable and safe living environment? Y ☐ N ☐ Info unavailable ☐

Are you living… with family ☐ in care ☐ independently ☐ homeless ☐ in VIHA funded resource ☐

Where do you plan on living after the program?

19. Do you have any current involvement with the legal system? Y ☐ N ☐ Unknown ☐

Are you on probation? Y ☐ N ☐ Unknown ☐

Did someone tell you that you have to be here? (Legally mandated) Y ☐ N ☐

Additional information:

Family History

Family history of substance use? Y ☐ N ☐ Unknown ☐

Family history of mental illness? Y ☐ N ☐ Unknown ☐

Family history of trauma? Y ☐ N ☐ Unknown ☐

What role does culture/ethnicity play in your family?

How are special events celebrated?

Who are you closest to in your family?

Are there any significant events that have happened in your family?

Who in your family wants to be involved in your changes?

How can they best support you?

Follow up call is made to the family member(s) Y ☐ N ☐ Left Message ☐

What is the family preference for their level of involvement in supporting the youth?

Permission to speak with family is denied by the youth. ☐

Service Provision

Have you ever received counselling? No ☐ In Past ☐ Currently ☐ Unknown ☐

(Why? When? With whom? Where?)

Is there anything else we need to cover today to prepare you for the next steps?