

REFERRAL

180° YOUTH DETOX AND SUPPORTIVE RECOVERY

REFERRAL INFORMATION

Date of Referral (D/M/Y) Referral Source Name
 Referral Source Email Phone
 Referral Source Office Fax

YOUTH INFORMATION

Name DOB (D/M/Y) M F TG NB
 Indigenous? Y N Status Card # Band Nation
 Height Weight Eye Colour Hair Colour Care Card #
 Current Address Phone
 Street City Postal Code
 Parent/Guardian Relationship
 Current Address Phone
 Street City Postal Code
 Emergency Contact Phone
 Family Doctor Ph Fax
 Social Worker Ph Fax
 Other Professional Ph Fax
 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 1 st use	# of days used in past 30 days	Current Use Y N	Pattern & Date of last use	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:

MAST Score:

DAST Score:

Please describe presenting issues? Why is the youth wanting to come to the 180 program now?

Please identify youths strengths, resiliences, interests, and preferences.

Describe any risk taking behaviours:

Describe any challenges/life stressors:

School

Attending school? Y N Grade School

Favourite Subjects

Learning Challenges? Y N Info unavailable Literacy Level Info unavailable

Have they had an Individualized Education Plan done? Y N

Have they had an Psycho-Educational Assessment done? Y N

Employment

Currently working? Y N Where?

Describe some of your work history

Do you want employment while in the program? Y N

Immediate Risks and Medical History

Describe any current or historical medical concerns? (e.g., asthma, allergies, seizures) Y N

Prenatal Exposure? Y N Unknown

Developmental milestones met? Information unavailable

 Eye sight? Hearing? Speech? Language function?

Are immunizations up to date? Y N Unknown

Describe:

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

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

 By whom? Indicate Primary Diagnosis:

Are you currently taking any prescription drugs? Y N

Describe:

Are you on any Psychotropic Medication? Y N

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

Do you personally have any concerns about your emotional/mental health issues? Y N

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

Describe:

Is there a history of suicide ideation or attempts? If yes, please provide details. Y N UK

Is there a history of trauma, abuse, neglect, or violence? If yes, please provide details. Y N UK

Is there a history of cruelty to animals? Y N UK

Is there a history of fire setting? Y N UK

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?

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

Have you been in custody before? Y N Unknown

Does youth smoke? Y N Does youth vape? Y N

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

Previous Treatment and Program Planning

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

Please describe any previous counselling and how you responded?

Have you attended a Treatment Program before?
If yes, describe: Yes No Unknown

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

List people who are positive supports for the youth

Support Person	Relationship/Agency/Role	Anticipated Involvement

Please describe the emergency discharge plan:

Name: Phone Number:

Address:

Additional Information:

When in the 180° program, you will be residing in a JHSNI approved carehome. Are there any environmental concerns we need to be aware of?