

LAST DOOR YOUTH PROGRAM REFERRAL PACKAGE

REFERRAL SOURCE GUIDELINES

Listed below is a general outline of the referral, interview and intake process at Last Door Youth Program.

1. Contact Last Door Youth Program at 604 520 3587 to determine bed availability and funding options.
2. Complete and fax the Referral Package, Tuberculosis Test Results, funding confirmation and other requested reports (these may be faxed separately).
3. Arrange for the client to attend a program “viewing” and/or screening interview. If your client is attending a screening interview and an intake is advised, program participation commences immediately following program acceptance.
4. Upon intake Clients are assigned a case manager who will be the primary care contact for referral sources and family.
5. Visits with clients must be prearranged and are limited to weekday onsite visits until the client is stabilized as determined by LDYP staff. Families are encouraged to contact staff by phone or email to receive updates during the stabilization process.
6. The program length is recommended a minimum of ninety days. The length of stay is determined by individual needs and abilities. Additional program participation will be reviewed with the client and his support team.
7. All medications (prescription and non prescription) must be turned into the office. Medications are dispensed as per Program Doctor’s orders and Community Care Guidelines.
8. Please encourage the client to contact Last Door Youth Program to discuss appropriate items to bring with him to the program. Some clients choose to bring recreational equipment, musical instruments, stereos, etc.

Contact

Last Door Youth Program
109 Ash Street, New Westminster, BC
V3M 3R3
Tel: 604-520-3587
Fax: 604-521-1889
youth@lastdoor.org
www.lastdoor.org

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REFERRAL SOURCE

Referral Date: _____ Made By: _____

Agency: _____

Agency Address: _____

Telephone: (_____) _____ Fax: (_____) _____

How many sessions have you had with the client? _____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Address: _____

Telephone: (_____) _____ Message: (_____) _____

PHN: _____ SIN: _____

CONTACTS

Family Contact: _____ Phone: (_____) _____

A&D Counsellor: _____ Phone: (_____) _____

Social Worker: _____ Phone: (_____) _____

Probation Officer: _____ Phone: (_____) _____

Legal Guardian: _____ Phone: (_____) _____

Caregiver: _____ Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____

REFERRAL MOTIVATION

Condition of court Condition of Employment Family request Self motivated

DETAILS OF FINANCIAL RESOURCES

MHR FAW: _____ Office: _____ Telephone: _____

Private (Fee for Service Contract) _____

Other _____

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DRUG USE HISTORY:

Name	Age of first use	Method of use	Daily	Few times per week	Four or less times per month	Monthly	Less than 12 times per year
Alcohol							
Cannabis							
Cocaine and/or crack							
Hallucinogens (LSD, Mushrooms, XTC, PCP, etc)							
Heroin							
Illicit Methadone							
Inhalants							
Meth/amphetamine							
Nicotine							
Opiates (ie: morphine, Demerol)							
Prescription drugs Name: Name:							
Rave/designer drugs							
Other Name:							

COUNSELING EXPERIENCES:

Type	Program Counselor Name	Age	Length / # of sessions	Outcome
Withdrawal Services				
A & D Outpatient Clinic				
Psychologist / Psychiatrist				
Mental Health				
Residential Treatment				
Day Treatment				
Family Counseling				

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LEGAL INVOLVEMENT:

- Not involved in CJS On Probation Until? _____
- Pending Charge(s): _____
- Charged: _____
- Does the client have any legal issues associated with inappropriate sexual behavior or fire setting charges?
 No Unknown Yes

MEDICAL AND PSYCHOLOGICAL FUNCTIONING AND HISTORY

1. Has the client experienced any form of physical, sexual, emotional, mental or spiritual abuse?:
 Yes No Unknown
2. Does the client have a history of aggressive behavior: Yes / No
Peers Authority figures Family Siblings Other _____
Describe: _____
3. Does the client have a history of suicide ideation or suicide attempts? Yes No Unknown
4. Does the client have a history of self harm / mutilation? Yes No Unknown
5. Is the client prescribed medication? Name: _____ Dosage: _____
Current Diagnosis: _____ Physician _____
6. Previous/Suspected Diagnosis (ADHD, ADD, FAE/FAS, OCD, Depression, Anxiety Schizophrenia, Disordered eating, etc): _____
7. Does the client have any health issues (allergies, heart irregularities, Hepatitis, HIV, Tuberculosis, asthma, head injury, skin conditions, diabetes, nutrition needs, hygiene issues etc)? _____

8. Is the client displaying any withdrawal symptoms? Yes No Unknown

EDUCATION / EMPLOYMENT

- Grade 12 Completed Expelled Choosing not to attend Currently attending _____
- Last grade level enrolled in: _____ Regular School Alternate School
 - Currently employed No Yes
 - Types of employment _____
 - Employer _____

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FAMILY AND SOCIAL HISTORY AND SUPPORT

Family supportive of client's treatment: No Yes, Who? _____

Does any family and / or significant others have substance/ problem gambling issues presently/past? No Yes

Who? _____

Who does the client want to be involved in his treatment process (healthy peers, social worker, Doctor, mentors, etc?)

Comments: _____

CULTURAL AND SPIRITUAL

Describe the client's personal cultural and spiritual interests / beliefs / activities: _____

LEVEL OF MOTIVATION FOR TREATMENT

What are the key issues for this client? _____

Do you believe the client is aware of the level of motivation required to participate in a residential program?

Yes No Unknown

What goals does the client hope to obtain while in treatment (substance misuses issues, educational/vocational, support network etc)? _____

DISCHARGE PLAN:

Program complete: _____

Program Incomplete: _____