

# 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)? \_\_\_\_\_

\_\_\_\_\_

**DISHCHARGE PLAN:**

Program complete: \_\_\_\_\_

Program Incomplete: \_\_\_\_\_