LAST DOOR
BREAKING THE CHAINS OF ADDICTION SINCE 1984

REFERRAL SOURCE GUIDELINES

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

1. Contact Last Door Recovery Centre at 1 888 525 9771 to determine bed availability and funding requirements.

2. Please complete and fax the Referral Package, provide funding confirmation and any other requested reports (these may be faxed separately) to 604 525 3896

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. 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.

6. Visits with clients must be prearranged and are limited to weekday onsite visits until the client is stabilized as determined by staff. Families are encouraged to contact staff by phone or email to receive updates during the stabilization process.

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 Recovery Centre 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 Adult Program
323 8th Street, New Westminster, BC
V3M 3R3
Tel: 604-525-9771
Fax: 604-525-3896
adult@lastdoor.org
www.lastdoor.org

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LAST DOOR RECOVERY CENTRE
REFERRAL PACKAGE

REFERRAL SOURCE

Referral Date:________________________ Made By: ________________________

Agency: ____

Agency Address: ____

Telephone: (______) ________________________ Fax: (____) ________________________

How many sessions have you had with the client? ______

CLIENT INFORMATION

Name: ________________________ Age:__________ Date of Birth:________________

Address: ____

Telephone: (______) ________________________ Message: (____) ________________________

PHN: ________________________ SIN:________________________

CONTACTS

A&D Counsellor: ________________________ Phone: (______) ________________

Family Contact: ________________________ Phone: (______) ________________

Probation Officer: ________________________ Phone: (______) ________________

Emergency Contact: ________________________ Phone: (______) ________________

REFERRAL MOTIVATION

☐ Condition of Court ☐ Condition of Employment ☐ Family ☐ Self motivated

DETAILS OF FINANCIAL RESOURCES

☐ MHSD FAW:________________ Office:____________ Telephone:________________

☐ Private (Fee for Service Contract) ________________________________

☐ Insurance Provider ________________________________

☐ 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 ☐ Spouse ☐ Other ______________

Describe: ______________________

3. Does the client have a history of suicidal 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: _______ ☐ University/College ☐ Trade School
- Currently employed ☐ No ☐ Yes ______________________
- Currently employed ☐ No ☐ Yes ______________________
- 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: ____

____

RELATIONSHIP HISTORY AND SUPPORT

Partner supportive of client's treatment: ☐ No ☐ Yes, Who? ____

Does partner and / or significant other have substance/ problem gambling issues presently/past? ☐ No ☐ Yes

Who? ____

Does the client have children? (Ages Names Gender) ____

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)? ____

____

DISHCARGE PLAN:

Program complete: ____________________ Program Incomplete: ____________________