Referring Counsellor please fax completed forms to Peak House at (604) 253-3581.

Peak House: Pacific Youth & Family Services Society
Referral – Part One

B.C. CARE CARD NUMBER: ______________________________ If Status, provide number: ___________________
(Referral cannot be accepted without Personal Health Care Number)

Legal Name: _________________________________ Preferred Name: ____________________________

Gender: M/F/T*/Other:______________________ Preferred Pronouns (he/she/they/etc.): ________

Ethnicity (Circle all that apply): Caucasian/Asian/Aboriginal (Self-Identified)/African/Latino(a)/Middle Eastern/South Asian/Other: __________________________________

Date of Birth: Month ________________ Day _________ Year ________

Address: ____________________________________ City:________________ Postal Code:_________

Telephone Number: __________________________ (Is it ok to leave a message? Yes ☐ No ☐)

Email Address: ____

Parent(s) Names:____

Do you reside with your parent(s)? Yes ☐ No ☐

If not residing with Parent(s), please provide the following:

a) Legal Guardian: Name: _______________________________ Phone Number: _____________

Address: ____________________ City: _________ Postal Code: _________

Email Address: ____

b) Caregiver: Name: _______________________________ Phone Number: _____________

Address: ____________________ City: _________ Postal Code: _________

Email Address: ____

c) Relationship to Caregiver (i.e. foster parent, aunt, friend, etc.): ______________________________

Alcohol and Drug Counsellor: _______________________ Agency or Program: ________________________

Phone: _____________________ Fax: ________________Email Address: _____________________________

If for any reason the youth leaves Peak House prematurely, the person or agency that will pick them up is:
This name must match the signed 'Housing' sheet on the next page

Name: ______________________________________ Phone Number: ____________________________________

Agency: ____________________________________Address: ____

Housing

One of the major obstacles to successful completion of treatment is the lack of supportive housing post-treatment. It is very difficult for youth to focus on setting treatment goals, working towards completing those goals and moving forward with their lives when they do not know where they will be living or who will support them in their preferred way of being. While we would not deny access to treatment for those youth who do not have the necessary supports in place, we must insist, **at a minimum**, that if a young person decides to leave the program early, or, if Peak House asks a young person to leave the program early that there is a person that will take them **immediately.** This includes both scheduled and unscheduled breaks and passes from the program. It is a requirement that this person is available and accessible for the duration of the young person's stay in the Peak House program.

I agree to assume full responsibility for taking ________________________________ immediately, should they, for any reason, leave Peak House.

***Name:** _________________________________ **Phone Number:** ________________________________

Address: _______________________________ **City:** _______________ **Postal Code:** ______________

Relationship to Client: ____

Signed: _______________________________________ **Date:** __________________________________

*In the event the above is not the legal guardian or caregiver, consent is required.

_________________________________ _________________________________
Legal Guardian/ Caregiver Name **Legal Guardian/ Caregiver Signature**

Medication Policy & Protocol

Peak House does not pay for costs not covered by the Provincial Medical Services plan i.e. prescriptions, physiotherapy, dental, etc.

If your youth requires a prescription or medical service not covered by MSP, how will that cost be covered? (Please indicate by checking below & providing further information as needed)

Parent/Legal Guardian Extended Health Plan

Group ID: ______________________________ Rx ID: ______________________________________

Certification Number: _____________________ Name of Insurance Provider: _____________________

Ministry for Children and Family Development

PHN:__________________________________

Status Coverage

ID Number: _____________________________

Other

____

____

In adherence to best care and safety practices, Peak House staff can only administer prescription or over-the-counter medications (including vitamins) that are prescribed by the Peak House Physician and dispensed through our Pharmacy. If your young person is currently on medication of any kind, please follow these guidelines in preparing for them to come into our program:

1. Provide the name of your young person's prescribing physician below.

   Physician's Name: ____

   Address: ____

   City: ______________________________________ Postal Code: ___________________________

   Phone: ____________________________________ Fax: _________________________________

   Our Pharmacy and physician will coordinate with the above physician to ensure medication is available to your young person on day of intake.

2. If medical costs are not covered by the payment options available above, please contact the Intake and Assessment Counsellor at 604-253-6319.

3. **DO NOT bring medication (new or opened) to Peak House on day of intake, as our staff are unable to administer any medication (including over-the-counter medication, supplements, vitamins) not provided by our Pharmacy.**

In order to provide the best service possible to our clients, both pre-treatment and during treatment, it is essential that we work collaboratively[1] with all professionals who provide service to a referred youth. We require the following information for each professional who is providing service to this referred youth.

Social Worker

Name: ______________________________ Telephone: ______________________

Fax: ______________________ E-mail: __________________________________

Probation Officer

Name: ______________________________ Telephone: ______________________

Fax: ______________________ E-mail: __________________________________

Mental Health Worker

Name: ______________________________ Telephone: ______________________

Fax: ______________________ E-mail: __________________________________

Family Support Worker

Name: ______________________________ Telephone: ______________________

Fax: ______________________ E-mail: __________________________________

Psychiatrist

Name: ______________________________ Telephone: ______________________

Fax: ______________________ E-mail: __________________________________

Other Professionals

Name: ______________________________ Telephone: ______________________

Fax: ______________________ E-mail: __________________________________

Name: ______________________________ Telephone: ______________________

Fax: ______________________ E-mail: __________________________________

[1] Refer to Page 3 – Consent for Referral and Release of Information

Consent for Referral and Release of Information

(To Be Signed by Young Person)

I have read the Peak House program description. I have read, and understand the referral forms. I know that Peak House is a voluntary program and this application is being made with my approval and consent.

Client: ______________________________ ______________________________
(please print name) (signature)

Witnessed by: ______________________________ ______________________________
(please print name) (signature)

It may be necessary for Peak House to clarify or request[2] additional confidential information, from the persons you have listed on your application (i.e. A&D Counsellor, P.O., S.W., etc), for the purpose of ensuring that we have complete information and a total understanding of the information given, prior to intake.

I consent[3] to the following persons discussing, with the persons listed on my referral, information contained in my referral to the Peak House Program:

1. **Peak House Assessment Counsellor**
2. **Peak House Clinical Counsellor**
3. **Peak House Doctor**

Client: ______________________________ ______________________________
(please print name) (signature)

Witnessed by: ______________________________ ______________________________
(please print name) (signature)

If there is any person listed on your application we do not have permission to speak with? Please specify below.

[2] Failure to give consent may affect acceptance of referral
[3] This consent is valid until intake or cancellation of referral

Description of Family and/or Support System

1. Who do you currently live with and how long have you been living there?

2. Are you planning to continue this living arrangement after treatment? If not, what are your plans?

3. Is there anything that you think we should know about your living arrangements and/or family that may be relevant to the work you will do at Peak House?

4. Who do you include as part of your “family”?

5. Do you have any close and/or important relationships outside of your family/caregivers? If yes, please describe.

6. If you have a significant relationship outside of your “family” are your caregivers supportive of that relationship? If not, why?

7. What are your strengths as a family?

8. What are your expectations for yourself and your family/support system in the work you will do at Peak House?

Getting to Know You

(Please answer the following questions so that we can better understand you. You are welcome to skip any questions that you do not feel comfortable answering.)

1. What are your cultural/religious spiritual practices? Please describe.

2. How may Peak House support you with these practices?

3. How have drugs and alcohol impacted these practices?

4. How would you identify your sexual orientation (Lesbian/ Gay/ Bisexual/ Queer/ Two-Spirit/ Polysexual/ Asexual/ Questioning/ Heterosexual/ Other)?

5. Do you have concerns related to your sexual orientation, or do you ever feel awkward about your sexual orientation?
   Not at all ☐ A little ☐ Somewhat ☐ A lot ☐ Unsure ☐

6. How would you identify your gender identity (Female/ Male/ Trans*/ Gender Variant/ Gender Creative/ Genderqueer/ Questioning/ Intersex/ Two-Spirit/ Other)?

7. Do you have concerns related to your gender identity, or do you ever feel awkward about your gender identity?
   Not at all ☐ A little ☐ Somewhat ☐ A lot ☐ Unsure ☐

8. Is your reason for getting help related to any issues around your sexual orientation or gender identity?
   Not at all ☐ A little ☐ Somewhat ☐ A lot ☐ Unsure ☐

9. Is your substance use linked to experiences of discrimination (sexual orientation/ gender identity or expression/ culture/ ethnicity/ spiritual practices/ class/ other)?
   Not at all ☐ A little ☐ Somewhat ☐ A lot ☐ Unsure ☐

Description of Educational Experiences

1. Are you still in school? Yes ☐ No ☐

   If you are attending school now, current grade: ________

   What school? ______________________________

   If you are not in school, last grade completed: _________

   When (month/year): ________________________

   What school? ______________________________

   Are you currently suspended or expelled? Yes ☐ No ☐

   If yes, is this related to substance use? Yes ☐ No ☐

2. What are some successes or positive experiences you have had at school?

3. What are some challenges or difficulties you have had at school?

4. When you were in school, did you receive specialised assistance from people or technology? If so, please explain.

5. How has substance use affected your school experience?

6. Please give the name and contact information of your school contact person (if applicable)

   Name of School Contact: ____

   Phone Number: ____

   Email: ____

PEAK HOUSE

VSB VANCOUVER BOARD OF EDUCATION
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Students attending Peak House remain registered at their school, and this form provides consent for the Vancouver School Board teacher at Peak House to liaise with home school/district staff and/or community contacts. For questions or concerns, please contact:
Michelle Davis – *Provincial Resource Teacher at Peak House School* *(604) 358-0352* *mdavis@vsb.bc.ca*

Student's Name ____
SURNAME FIRST NAME

Birthdate____
YEAR MONTH DAY

School____

I authorize the Vancouver School Board @ Peak House Provincial Resource Program, to hereby:

❑ Obtain information and/or records from other appropriate agencies.

❑ Release information and/or records on a strictly confidential basis to other appropriate agencies.

❑ Discuss pertinent information with representatives from appropriate agencies on a strictly confidential basis.

I request the Vancouver School Board @ Peak House Provincial Resource Program to:

❑ Release copies of VSB/Peak House School Assessment(s) to me.

Please note that if the student transfers to another school or district, all reports will be sent to that school/district.

Parent/Guardian name: ____

Home Mailing Address:______________________________City:______________

Postal Code |_|_|_| |_|_|_| Telephone Number____________________

Parent/Guardian email: ____

Parent/Guardian Signature________________________Date______________

VSB REL-DL-001 (Rev.4, 99-01)

Description of the Problem

1. What are your present concerns regarding the ways in which drugs are affecting you?

2. How are drugs getting in the way of you having the life you want?

Description of Substance Use

1. Please describe your use of the following substances:

	# of times used past month	# of times used past year	Age of first use
Nicotine	______________________	____________________	___________
Alcohol	______________________	____________________	___________
Marijuana	______________________	____________________	___________
Cocaine	______________________	____________________	___________
Crack	______________________	____________________	___________
Heroin	______________________	____________________	___________
Crystal Meth	______________________	____________________	___________
Ecstasy	______________________	____________________	___________
Inhalants	______________________	____________________	___________
LSD	______________________	____________________	___________
Mushrooms	______________________	____________________	___________
Prescription Drugs	______________________	____________________	___________
Other	______________________	____________________	___________

2. Which substance would you identify as being most problematic at this time?

3. Have you ever injected a drug? Yes ☐ No ☐

4. Have you ever:
    a. Used drugs or alcohol before or during school? Yes ☐ No ☐
    b. Missed school or work because you were high or hung-over? Yes ☐ No ☐
    c. Been told that you should cut down on or stop using drugs? Yes ☐ No ☐
    d. Used drugs or alcohol three or more days in a row? Yes ☐ No ☐
    e. Used alcohol or drugs while doing something that could have resulted in serious accident (i.e. driving, swimming, boating)? Yes ☐ No ☐
    f. Used substances to try to lose weight, build strength or improve your athletic performance? Yes ☐ No ☐

5. Have you ever been in a treatment program (including day programs) to get help with drugs and/or alcohol use? Yes ☐ No ☐

    If yes, when? ______________________________________

    What program? ____________________________________

    How long did you attend? ____________________________

    For which substances? ______________________________

6. Have you ever been in a detox facility? Yes ☐ No ☐ If yes, please provide details:

7. Do you attend, or have you ever attended, community support groups? Yes ☐ No ☐ If yes, please provide details:

Description of Legal History

1. Please list any charges that resulted in a conviction.

2. If you were convicted of an offence, were you sentenced to:

   Probation: Yes ☐ No ☐
   Custody: Yes ☐ No ☐

3. How old were you at the time of your first interaction with the police/legal system?

4. Have you ever had a weapon taken away from you? Yes ☐ No ☐

5. Do you currently have any outstanding charges[4] against you? Yes ☐ No ☐ If yes, what for?

6. Do you have any upcoming court dates[5]? Yes ☐ No ☐ If yes, when?

7. Are you currently on probation[6]? Yes ☐ No ☐ If yes, until when?

[4] Outstanding charges must be dealt with prior to intake
[5] Court dates must be dealt with prior to intake
[6] A copy of Probation Order must be forwarded to Peak House prior to intake.

Description of Psychological or Social History

1. Have there been times when you have had serious difficulty with:
   a. Depression Yes ☐ No ☐
   b. Tension or anxiety Yes ☐ No ☐
   c. Hallucination or flashbacks Yes ☐ No ☐
   d. Fear, worry, or panic Yes ☐ No ☐
   e. Anger Yes ☐ No ☐
   f. Failure or dissatisfaction with yourself Yes ☐ No ☐
   g. Extreme loneliness Yes ☐ No ☐
   h. Body image concerns Yes ☐ No ☐
   i. Other ___________________________ Yes ☐ No ☐

2. Have you struggled with disordered eating, restricting, purging, bingeing or over-exercising?
   If yes, please explain: Yes ☐ No ☐

3. Have you had thoughts about harming yourself in the last six months? Yes ☐ No ☐
   a. Have you acted on such thoughts Yes ☐ No ☐
      If yes, when? ________________

   b. Have you ever thought about harming others? Yes ☐ No ☐
      If yes, please explain:

4. Have you had thoughts about suicide in the last six months? Yes ☐ No ☐
   a. Have you acted on such thoughts? Yes ☐ No ☐
      If yes, when? ________________

5. Have you ever seen a mental health worker/psychiatrist? Yes ☐ No ☐
   If yes, for what reason and when?

6. Were you prescribed medication? Yes ☐ No ☐
   If yes, are you still taking medication? – if not, why did you stop?

7. Are you currently seeing a mental health worker/psychiatrist? Yes ☐ No ☐
   If yes, for what reason?

8. Are you currently on medication? Yes ☐ No ☐
   If yes, what medication(s) and how long have you been taking it?

Medication Name & Dose	Length of Time Taking Medication

9. In your opinion, is the medication useful/effective? Yes ☐ No ☐
   Please explain.

If you have been, or are currently, under the care of a mental health worker or psychiatrist, we will require a copy of your assessment PRIOR TO INTAKE.

Description of Physical Health

1. Do you have a family doctor? Yes ☐ No ☐
   If you do not have a family doctor, how are your medical needs attended to?

2. Peak House has its own medical doctor who visits once a week – is this going to be helpful for you?
   Yes ☐ No ☐ Why?

3. Is there anything about your physical well-being that is of concern to you right now?

4. If you have concerns about your physical health, have you seen a doctor, or do you have plans to see a doctor?

5. Do you have regular dental checkups? If so, date of last checkup.

6. If you do not have regular checkups when was the last time you saw a dentist?

7. Do you have any dental concerns? If so, please describe.

8. When was the last time you had an eye exam?

9. Do you require corrective lenses (eyeglasses or contacts)? Yes ☐ No ☐
   Please remember to bring your corrective lenses to Peak House if you require them.

Peak House: Pacific Youth & Family Services Society

Referral – Part Two

To be completed by referring counsellor (use additional sheets as necessary)

1. What are the key areas of concern, as agreed upon by you and your client?

2. How long have you been working together?

3. How many sessions have you had together?

4. Based on your assessment, is there a need for family counselling? Please Describe.

5. Have you already engaged in family work together?

6. Why do you think that Peak House is a right fit for this person?

7. Please indicate any barriers you feel may impact this persons ability to fully participate in the program. From your perspective, how can Peak House support their success?

8. Please tell us about their strengths.

Please attach any medical/psychological assessments pertaining to your client.

Peak House: Pacific Youth & Family Services Society

Referral – Part Three

The following questions are to be completed by parents/ legal guardians or primary caregivers.

Name of Youth: ____

Your Name: ____

Relationship to Young Person: _________________________________

1. How have drugs and/or alcohol affected your young person?

2. How has your family been affected?

3. Is your young person struggling with problems other than drugs or alcohol? If yes, describe.

4. What are their strengths?

5. What are your strengths as a family?

6. Tell us about their interests (i.e. recreation, sports, art, etc)?

7. What are your expectations of the Peak House program?

8. What are your expectations of your young person?

9. Your involvement and support throughout your young person's stay in our program is crucial. Involvement may include telephone and video conferences, family meetings, family night visits/participation, and planned client passes. Please indicate if you have any concerns about this or if there are barriers that would interfere with your involvement in any of the above.

10. Is there anything else you would like us to know?

Health Information

(To be completed by parent/ legal guardian or primary caregiver)

Name of Family Physician: ________________________________

Phone Number: ____

Date of last medical examination: ___________________________

Date of last dental examination: ____________________________

Date of last eye examination: ______________________________

1. Are the young person's immunizations up-to-date? Yes ☐ No ☐

2. Indicate whether the young person has a history of: (Circle those that apply)

   Diabetes | Asthma Allergies | ADHD/ADD | Hepatitis/HIV

   Depression/Anxiety | Anorexia/Bulimia | Other: ______________________

3. Please provide details on any item circled above:

4. Has your young person ever:

   a) Visited an emergency room? Yes ☐ No ☐ If yes, when and for what reason?

   b) Been hospitalized? Yes ☐ No ☐ If yes, when and for what reason?

   c) Been in a Mental Health Program[7]? Yes ☐ No ☐ If yes, where and when?

[7] A treatment summary will also be required.

Health Information continued

(To be completed by parent/ legal guardian or primary caregiver)

5. List any medication currently prescribed

Name of Medication	Purpose of Medication	Start Date

a). Comments on efficacy of current or previous used medications

b). Any medication allergies or adverse reactions to medications? Yes ☐ No ☐
If yes, please specify.

6. List the name and purpose of any non-prescription medication or vitamins used regularly

Medication Name	Purpose of Medication	Start Date

a). Comments on efficacy of current or previous used medications.

b). Any medication allergies or adverse reactions to medications? Yes ☐ No ☐
If yes, please specify.

7. Do you have any current concerns about your young person's health?

A Medical Form Completed by Family Physician will be required prior to Intake.

Consent for Referral

(To be signed by young person)

I have read and understand the Peak House program description, program expectations and referral forms. I have completed all portions of the referral except those that are the responsibility of the referring counsellor and parent/guardian. I know that Peak House is a voluntary program, and I voluntary agree to support this referral.

Client Signature: ________________________________ **Date:** _____________________________

Legal Guardian Signature: ________________________ **Date:** _____________________________

Peak House
2427 Turner Street
Vancouver, BC; V5K 2E7
Referral and Assessment Information

Peak House: Pacific Youth & Family Services Society

Referral – Part Four

(To be filled out by Physician)

Client Name: ____

Date of Birth (mm/dd/yyyy): ____________________________ **PHN:** ___________________________

Client Release

I, _______________________________, hereby request and permit my physician, __________________________, to release my medical history to the Peak House physician, in addition, I agree to the release of any medical information by the Peak House physician to my physician. The photocopy of my signature on this form is as valid as the original.

Signature of Client: _____________________________ **Date:**___________________________

This consent for release of information is valid from the above date to program completion date.

To the Physician

The above named client is to be medically assessed as a potential participant in our ten (10) week live in treatment program. Our program is designed to help youth who acknowledge that their alcohol and/or drug use has interfered with their effective functioning and who are physically and mentally ready to participate in a program of intense counselling activities. Peak House requests all clients to have a complete physical examination prior to admission. All clients will be examined by our Sessional Physician on admission, however, it is expected that clients admitted to Peak House will be able to participate mentally, emotionally, and physically in the treatment program without the need for ongoing medical care. Emergency care is available on a twenty-four (24) hour basis at a local hospital emergency department or a local Care Clinic.

Please complete the attached medical assessment form to ensure that all physical and medical needs are identified.

Completed form can be faxed to: 604-253-3581
Telephone: 604-253-6319

(To be filled out by Physician)

Client Name: ___________________________________ **PHN:** ___________________________________

Date of last alcohol/drug use: _____________________________

1. Does the client have a history of seizures? Yes ☐ No ☐
   (If yes, please provide details)

2. Does client have a communicable disease? Yes ☐ No ☐
   (If yes, please provide details- include HIV/HEP/STD status)

3. Does client have a history of serious co-existent medical condition, ie hypertension, GI bleed? Yes ☐ No ☐

4. Has there been any diagnosis or treatment of depression Bipolar disorder, personality disorder, eating disorder, or other mental health issue? (If yes, please provide details) Yes ☐ No ☐

5. Is client currently on medication for any of the above? Yes ☐ No ☐
   (If yes, please provide the name of medication, dosage and any other details)

6. Is client an IV drug user? Yes ☐ No ☐

7. Is the client pregnant? Yes ☐ No ☐

   LMP: _______________ Contraception: ______________

8. Does client require special diet? Yes ☐ No ☐
   (If yes, please provide details)

(To be filled out by Physician)

Client Name: ______________________________ **PHN:** ______________________________

9. Function Inquiry - Is there any disorder of the following?

		If Yes,	Active or Resolved?		
Hair, Skin, Nails (especially current or Recent infections or infestations)	Yes ☐	No ☐	☐	☐	
Ear, Nose, Throat	Yes ☐	No ☐	☐	☐	
Musculo Skeletal System	Yes ☐	No ☐	☐	☐	
Blood, Lymphatic System	Yes ☐	No ☐	☐	☐	
Cardio Vascular System	Yes ☐	No ☐	☐	☐	Respiratory
System	Yes ☐	No ☐	☐	☐	
GI System	Yes ☐	No ☐	☐	☐	
GU System	Yes ☐	No ☐	☐	☐	
CNS – especially seizures	Yes ☐	No ☐	☐	☐	Allergies
(please specify)	Yes ☐	No ☐	☐	☐	

____

____

a). Any issues with language functioning, including speech and hearing functioning? Yes ☐ No ☐
(please specify) ____

10. Please outline any past or current medical problems which may interfere with client's ability to participate fully in ALL aspects of the Peak House program.

Clients attending Treatment should be as free as possible from all drugs, especially those prone to cause dependency or interfere with cognitive function.

11. Has the client had a Tuberculosis test within the last 12 months? Yes ☐ No ☐
(if no, please refer to Public Health)

Result: Positive ☐ Negative ☐

If positive, was client referred to X-RAY? Yes ☐ No ☐

(To be filled out by Physician)

Client Name: ____________________ **PHN:** ____________________

12. Family History

Alcohol or Drug Problems/Concerns	Yes ☐	No ☐
Psychiatric History	Yes ☐	No ☐
Adopted	Yes ☐	No ☐
Prenatal exposure to alcohol, tobacco and/or other substances?	Yes ☐	No ☐

13. Physical Examination

Height: _______ Weight: ________ BP: ________ PR: ________

	Normal	Abnormal
Appearance	☐	☐
ENT	☐	☐
Hair, Skin, Nails	☐	☐
Reticuloendothelial System	☐	☐
Musculo Skeletal System	☐	☐
Cardio Vascular System	☐	☐
Respiratory System	☐	☐
Abdomen	☐	☐
CNS	☐	☐

Please comment on any abnormalities noted above and include any suggestions, insights, and/or treatment information.

I have examined the client and find them to be fit to attend treatment.

Physician Signature: ____________________ **Date:** ____________________

Name (please print): ____________________ **Phone number:** ____________________

Address: ____________________ **Fax Number:** ____________________

City: ____________________ **Postal Code:** ____________________