Referring Counsellor please forward completed referral to the Vancouver Coastal Health, Centralized Addictions Intake Team (CAIT) The team will be responsible for forwarding completed referrals to the admission committee.
Fax 604-681-1894 or email cait.youth@vch.ca
Inquiries 604-675-2455

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):_____ Pronoun(s) (he/she/they/other): _____

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

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.

Declining to pick up your young person may result in youth choosing to leave the program unsafely and/or jeopardising their ability and/or willingness to come back to the program. Peak House will support you with discharge, aftercare, or pass planning. We are a voluntary program with rules, expectations and boundaries. If you are unclear of our policies practice please speak with our Intake & Assessment Counsellor for more information 604-253-6319.

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 or Nurse Practitioner 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/Nurse Practitioner**
4. **Vancouver Costal Health, Centralized Addictions Team (CAIT)**

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: _____

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 _____

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? Yes ☐ No ☐
   If yes, please explain:

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, Yes ☐ No ☐
   ie hypertension, GI bleed?

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

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:** _____