Referrals are forwarded to Vancouver Coastal Health, Centralized Addictions Intake Team (CAIT) and reviewed by the admission committee. Email: cait.youth@vch.ca Inquiries: (604) 675-2455

To reach Peak House directly please contact our Intake & Assessment Counsellor
Fax: 604-253-3581 or email intake@peakhouse.ca Inquiries: (604) 253-6319

Peak House Program: Pacific Youth & Family Services Society

B.C. CARE CARD NUMBER: _____ Status 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/x)
Middle Eastern/South Asian/Other: _____

Date of Birth: Month _____ Day _____ Year _____Age _____

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.): _____

Referring 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 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: _____

☐ Please check if the Ministry for Children and Family Development is responsible for medical costs, including medications.

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.

List any current medications

Name of Medication	Dose	Purpose of Medication	Start Date

Are you taking Suboxone or Methadone? Yes ☐ No ☐
If yes, please ensure the information above includes information on this medication.

1. Prescribing physician.

   Physician or Nurse Practitioner Name: _____

   Address: _____

   Phone: _____ Fax: _____

   Our Pharmacy and Nurse Practitioner will coordinate with the above to ensure medication is available on the 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. **PLEASE 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 it is essential that we work collaboratively[1] with all professionals working with this client. Please let us know who is a part of the care team.

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 5 – Consent for Referral and Release of Information

Consent for Referral and Release of Information

To Be Signed by Client

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 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 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.

Some information to help us get to know you and your needs prior to coming in

Alcohol & Drug History

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

   What program? _____When? _____How long did you attend? _____

2. What substances do you identify as problematic in your life?

3. Give us an understanding of the problem. How often you use, how much, and anything else that feels important about your struggle with alcohol and/or drugs.

4. What are your goals? What do you hope to get out of coming to treatment?

We ask that youth have some time away from substances before coming in (so that you are not detoxing when you get here) If a bed was available right now, do you think you will need to attend detox before coming to Peak House? Yes ☐ No ☐

Legal System History

1. Do you currently have any outstanding charges[2] against you? Yes ☐ No ☐
   If yes, what are your charges?

2. Do you have any upcoming court dates[3]? Yes ☐ No ☐ If yes, when? _____

3. Are you currently on probation[4]? Yes ☐ No ☐

---

[2] Please forward a copy of your Probation Order to Peak House prior to intake.

Physical Health / Wellbeing

1. Have you struggled with disordered eating, restricting, purging, bingeing? Yes ☐ No ☐
2. Do you have a history of, or are you currently engaged in self-harming behaviour? Yes ☐ No ☐
3. Do you have a history of suicidal thoughts? Yes ☐ No ☐
4. Do you currently have thoughts of suicide? Yes ☐ No ☐
5. Do you have a history of, or are you currently thinking about harming others? Yes ☐ No ☐
6. Have you gone to the hospital in the last year for any of the above? Yes ☐ No ☐

   If yes to any of the above, let's talk further to find out how to best support you.

7. Please ensure the list of medication you are taking is completed on page 3
8. Do you have any allergies (including to medication, food, environment, other)? Yes ☐ No ☑
   If yes, please provide details

9. Do you have a copy of a negative Tuberculosis test within the last 12 months? Yes ☐ No ☐

   If no, a negative TB test is required within the first week of your stay. Please take care of this step with the help of your referring counsellor before your intake date if possible.

10. Is there anything about your physical health you want us to know about?

11. Do you have any mobility or other health information that may impact your ability to participate fully in programing? Please let us know if you require accommodation.

If a current assessment from your Mental Health worker or Psychiatrist is available please provide this in order to help us best support you during your stay with us.

This section is designed to provide the opportunity for a fuller picture and to help us to better contribute to the continuity of care around our shared client.

Peak House: Pacific Youth & Family Services Society

To be completed by referring counsellor

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. What goals would you identify as an area of focus during their stay with us? Please let us know of any work or planning that has been developed and/or initiated so that we can support the care planning for this youth.

5. Based on your assessment, is there a need for family counselling? Please describe.

6. Have you already engaged in family work together?

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

8. 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?

9. Please tell us about their strengths.

Peak House: Pacific Youth & Family Services Society

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

Your Name: _____

Relationship to Young Person: _____

1. Is your young person struggling with problems other than drugs or alcohol? That you would like us to be aware of?

2. What are their strengths?

3. What are your strengths as a family?

4. 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.

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

6. Do you have any concerns about their physical or mental health you would like us to be aware of?