Stepping Stones RECOVERY HOUSE FOR WOMEN

Confidential Self Referral Application

1535 Burgess Road Courtenay, BC V9N 8N1 Ph: 250-897-0360 Fax: 250-897-0316 Email: steppingstoneshouse@telus.net	Name:_____ Date:_____ Phone :_____

If this application is being filled out by a referring agent, please fill in the following details.

Referring Agent:	
Referring Agency:	
Phone #:	
Email:	
Fax #:	

Part 1: General Information

Email Address:_____

Address:_____

Date of Birth:_____(mm/dd/year)

SIN#_____PHN#_____

Gender: (Please Circle the one that applies) Female Trans MTF

Cultural/Ethnic Identity:_____

Status: (Please circle) Yes or No Status #:_____

Emergency Contact person:_____

Phone #:_____

Next of Kin:_____ Phone #_____

Relationship to you_____

Dependant children: Yes or No How many?_____

Who do the children reside with?_____

Is there MCFD involvement? Yes or No

Who has legal custody?_____

What were the circumstances that lead you to reach out for help?_____
_____
_____

Safety Concerns/ history or current violence in relationships? Have you been violent?_____
_____
_____

Restraining orders / no contact orders? Yes or No

Is there victim services involvement? Yes or No

Do you have legal concerns? Yes or No

_____
_____

Part 2: Release of Information (ROI)

Client authorization: My signature authorizes the release/ and or exchange of information between Stepping Stones Recovery House for Women Society staff and all the service providers noted below. This authorization is valid for pre-admission collaboration of care purposes, for the entire duration of my residence at Stepping Stones and my discharge and summary.

Client Signature:_____Date:_____

Referring Agent Identification/Verification: (if applicable)

Print Name:_____Date:_____

Signature:_____

Service Provider	Name	Agency	Phone and/or email
Physician(GP)			
Nurse Practitioner			
Addictions Counsellor			
Addictions Doctor			
Mental Health Worker			
Probation officer			
MCFD Worker			
Income Assistance			
Financial Aid worker			
Lawyer			

Other			
Other			
Other			
Other			

Part 3: Substance Use/Misuse History

Please answer the following questions to the best of your knowledge

Age you first used anything	
What is your drug of choice? (DOC)	
What other drugs do you use?	
When was the last time you used?	
Have you had any clean time in the past and how long?	
Have you been to treatment before?	
If so, How many times?	
Where?	
Did you complete?	
If not, Why?	

Do you struggle with any other addictions? (food, sex, love/relationship, shopping, gambling, social media)_____
_____
_____
_____

Part 4: Medical Information

This section is to be completed by your Physician (GP) or Nurse Practitoner. If you do not have a family physician you may access a walk in doctor for the purpose of filling out this section.

Medications currently taking (prescribed and over the counter)

Name	Current Dosage	Condition being treated	How long on this medication

Medical Diagnosis/Major Illness:_____

_____

_____

Other current Physical/Health Concerns:_____

_____

_____

Communicable Diseases: (Circle all that apply)

TB HIV Hep A B C Other_____

Date last tested:_____

Pregnant: Yes or No Weeks:_____ Due Date:_____

Family Physician: Yes or No

Name:_____Phone:_____

Are you on OAT Therapy? Yes or No

Which one are prescribed?_____Dose:_____

How long on OAT?_____

Prescribing physician:_____Clinic:_____

Allergies:(drug, food or environmental_____
_____

Special dietary needs:_____

Additional information about health concerns:_____
_____
_____

Part 5: Mental Health

Mental Health history/symptoms: (include psychiatric diagnoses, hospitalizations, other treatment)_____
_____
_____
_____
_____

Are they currently under the care of a psychiatrist? If so, for what?_____
_____

Psychiatrist's name:_____

Phone Number:_____

Self-Harming Behaviors: (include eating disorders, cutting, burning, other)_____
_____
_____
_____
_____

Suicide Risk: (circle the one that applies)

Current Ideation Previous attempts

Please provide details and dates of any attempts_____
_____
_____
_____

Additional information/comments:_____
_____
_____

Part 6: Financial

Stepping Stones Recovery House for Women requires the funding to be in place prior to intake.

If you are on income assistance we require you to fill out the proof of income form and get it filled out and stamped by your local ministry office. You can find this form on the website under the application tab.

Employment status: (circle what applies)

Full time part time unemployed

Income source: (circle what applies)

E.I. Pension Income assistance PWD PPMB LTD other_____

Part 7: Early Exit Transition Plan

It is understood that if I leave Stepping Stones Recovery Program, am discharged early, or I do not arrive for my scheduled intake at Stepping Stones Recovery House for Women, my early/emergency contact will be notified. I must also have a plan in place for shelter and transport prior to admission.

Client Name:	**Date of Birth**: dd/mm/year
Eary Exit Plan:	
Transportation Plan and Cost:	

Contacts for Early Exit Support

My emergency contact will also be called if I need to stay overnight at the hospital.

Name of contact for early exit plan:	Telephone: Email:
Name of emergency contact:	Telephone: Email:

I agree that I am responsible for all transportation costs and that I am responsible for knowing the fees associated with the bus, cab, and/or ferry. I must have these funds available to me upon intake.

Client signature:_____**Date:**_____

Staff signature:_____**Date:**_____