

# RECOVERY HOMES REFERRAL FORM

**Requested Program (please choose only one):**

- Talbot House
- Women’s Addictions Extended Care (Lacey House)
- St. Eleanor’s House

**Treatment Service:**

- Outreach
- Inpatient

**Referral Date:**

**CLIENT INFORMATION**

Client Name: \_\_\_\_\_ Pronouns: \_\_\_\_\_

PHN: \_\_\_\_\_ DOB (mm/dd/yy): \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Can we leave an identifying message?  Yes  No

Email Address: \_\_\_\_\_

Emergency Contact Name & Phone Number: \_\_\_\_\_

**REFERRAL SOURCE INFORMATION**

Referring Agency: \_\_\_\_\_ Referring Source Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**CURRENT SUPPORTS**

- Community Mental Health
- Psychiatry
- CCRB
- Narcotics Anonymous
- Addiction Worker (Date of Last Appointment: \_\_\_\_\_)
- Probation Services
- Child Protection (Is the file open?  Yes  No )
- Alcoholics Anonymous
- Family Support

**Additional Information:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BASED ON YOUR KNOWLEDGE, WHAT STAGE OF CHANGE BEST DESCRIBES THE CLIENT'S CURRENT OUTLOOK ON RECOVERY?**

- Precontemplation       Contemplation       Preparation       Action

**DOES THE CLIENT HAVE A DIAGNOSED MENTAL HEALTH DISORDER?**  YES       NO

If yes, please explain:

What is the level of severity on the client's functioning? (i.e., interpersonal interactions, ability to function in a group environment, level of insight, independence, etc.)

- Minimal       Moderate       Moderate-Severe       Severe

**ARE THERE ANY BARRIERS THAT MAY AFFECT THE CLIENT'S ABILITY TO PARTICIPATE IN PROGRAMMING?**

- Primary caregiver for dependent(s)       Non-compliant with prescribed medication(s)  
 Employment       Mobility       Transportation  
 Maintaining home/apartment       Learning Challenges       Literacy Level  
 Language       Other:

If there are any identified barriers, please provide additional details:

**CLIENT LEGAL INFORMATION**

Does the client have pending legal charges?  Yes       No

Is the client on probation?       Yes       No

Is the client on parole?       Yes       No

Are there any Emergency Protection Orders, no-contact, stay away orders, etc. involved?  Yes       No

If yes to any of the above questions, please provide additional details:

**TO BE COMPLETED IN COLLABORATION WITH THE CLIENT:**

Have you previously stayed or used outreach services at any of the Recovery homes?  Yes  No

If yes, what was the date of your previous involvement?

Are you currently on Opioid Replacement Therapy (ORT)?  Yes  No

What is your current length of abstinence and/or length of significant abstinence in the past?

If you struggle with a mental health disorder, please explain how you have been coping/managing to date:

Please provide details about your current problem behaviours and use (including substances, gambling, and sex behaviour):

Problem Behaviour:

Amount & Frequency of Use:


Please answer the following questions using the Readiness Ruler below:

On a scale of 0 to 10, how **IMPORTANT** is it right now for you to change?

1	2	3	4	5	6	7	8	9	10
Not at all Important								Extremely Important	

On a scale of 0 to 10, how **CONFIDENT** are you that you could make this change?

1	2	3	4	5	6	7	8	9	10
Not at all Important								Extremely Important	

**PERSONAL STATEMENT (TO BE COMPLETED BY THE CLIENT)**

What are your reasons for wanting to participate in one of the Recovery Homes?

How do you envision yourself at the time of discharge? What goals do you hope to have achieved by this time?

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Referring Source Signature: \_\_\_\_\_

Date: \_\_\_\_\_