Crossroads Centre

500 Oliver Rd.
Thunder Bay, ON, P7B 2H1
Telephone: 807.622.2730
Fax: 807.622.7587
www.crossroadscentre.ca

Sister Margaret Smith Centre

301 Lillie St. North
Thunder Bay, ON, P7C 0A6
Telephone: 807.684.5100
Fax: 807.622.1779
www.sjcg.net

Referral To:

Crossroads Centre:

☐ Pre – Treatment
☐ Post – Treatment

Sister Margaret Smith Centre

☐ Residential Services
☐ Out-patient Services

NOV 2020

THUNDER BAY INTEGRATED ADDICTION AND MENTAL HEALTH SERVICES
CONSENT TO OBTAIN / RELEASE INFORMATION

The protection of your privacy and the delivery of high quality care is our priority. In order to best serve you, a group of service providers, all committed to the protection of your privacy, are working together to support your decisions regarding your care. With your permission, we will share information with each other and with other agencies to support you in developing a plan of care that is designed to support your choices and decisions.

The following agencies are part of a service system which is designed to support you in reaching your personal goals.

Thunder Bay Counselling Addiction Services, Thunder Bay, ON	☑	Crossroads Centre Inc. Thunder Bay, ON	☐
St. Joseph's Care Group Addiction & Mental Health Services Thunder Bay, ON	☐	Dilico Anishinabek Family Centre Mental Health and Addictions Services Thunder Bay, ON	☐
Alpha Court Community Mental Health & Addiction Services, Thunder Bay, ON	☐		

If you are in agreement for the above named agencies and related programs to share assessment, treatment and case management information, please indicate your authorization by **initialing beside each relevant agency**.

In addition, there may be cause to share your personal health information with other care providers and agencies to support you in meeting your personal goals. If you are in agreement for the agencies listed below to obtain/release information with the authorized agencies in Thunder Bay Integrated Addiction and Mental Health Services please sign beside each agency indicating your authorization.

Consent to release/request information from the persons/agencies below:	Date	Signature
1. EMR (electronic medical records)TBRHSC&SJCG		
2. Consent to email referral package between agencies		
3._____		
4._____		

Having read and understood this form, I hereby authorize the identified agencies of Thunder Bay Integrated Addiction and Mental Health Services to Release/Request Information to/from each other and to/from the persons/agencies listed above. I also understand that I can withdraw my consent in writing at any time and that I can restrict the nature and type of information shared. This consent is considered valid for a period of six (6) months from the date of signature when it will be reviewed and renewed as required.

Name (Please Print) D.O.B. (dd/mm/yr) Signature

Reviewed and Witnessed By Date

Substitute decision maker _____
(Please Print)

Signature: _____ Date: _____ Relationship: _____

THUNDER BAY ADDICTION AND MENTAL HEALTH SERVICES

GUIDELINES FOR COMPLETING FORM

- Clinician / Case Manager will review the Consent to Obtain/Release Information with the client and address any questions/concerns prior to obtaining a signature

- Clinician / Case Manager will review the Consent to Service prior to obtaining client signature

- Copy of the Consent to Service and Consent to Obtain/Release Information will be filed on the clients' record

- The receiving agency conducting the initial intake will also provide a copy of their agency's privacy statement

CLIENT INFORMATION FORM	REFERENT INFORMATION
FIRST NAME: _____ **MIDDLE NAME:** _____	**DATE OF REFERRAL:** _____ **REFERRING AGENCY:** _____
LAST NAME: _____ **LAST NAME AT BIRTH:** _____ **EMAIL ADDRESS:** _____	
DOB:DD/MM/YEAR _____ **AGE:** _____	**NAME OF REFERENT:** _____
GENDER: ☐ MALE ☐ FEMALE ☐ OTHER	**EMAIL:** _____
HEALTH CARD # : **PROVINCE:** ON	**AGENCY ADDRESS:** _____
☐ **NO FIXED ADDRESS** ☑ **MAILING ADDRESS:** **STREET:** _____ **CITY:** _____ **PROVINCE:** ON **POSTAL CODE:** _____	**POSTAL CODE:** _____ **PHONE:** _____ **FAX#:** _____
HOME PHONE # : _____ **OTHER PHONE #:** _____ **CALL ALLOWED:** ☐ YES ☐ NO **MESSAGE ALLOWED:** ☐ YES ☐ NO	**CLIENT TYPE – PLEASE CHECKMARK** ☐ Client- Alcohol/Drug ☐ Client- Alcohol/Drug/Gambling ☐ Client- Gambling ☐ Family member of Alcohol/Drug Client ☐ Family member of Alcohol/Drug/Gambling Client
EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE #:** _____	**ETHNICITY- ETHNIC OR CULTURAL IDENTITY:** PRIMARY- _____ STATUS #- _____ BAND- _____

PLEASE CHECKMARK IN EACH SECTION THAT BEST FITS:

1. TREATMENT MANDATED\REQUIRED BY:

- [x] None
- [ ] Choice between treatment or jail
- [ ] Condition of probation/parole
- [ ] Child Welfare Authority
- [ ] Condition of employment
- [ ] Condition of school
- [ ] Condition of family
- [ ] Other _____

2. LEGAL STATUS:

- [x] No problem
- [ ] Awaiting trial\sentencing
- [ ] On probation- Start date: _____ (DD-MM-YEAR) End date:_____ (DD-MM-YEAR)
- [ ] On parole
- [ ] Incarcerated
- [ ] Other _____

3. RELATIONSHIP STATUS:

- [x] Married/partnered/common-law
- [ ] Spouses Name: _____
- [ ] Single (never married)
- [ ] Widow or widower
- [ ] Separated or divorced

4. EMPLOYMENT STATUS:

- [x] Employed full-time (includes self-employment)
- [ ] Employed part-time
- [ ] Unemployed (looking for work)
- [ ] Student\ retraining
- [ ] Program: _____
- [ ] Disabled (not working)
- [ ] Not in labour force
- [ ] Retired

5. HIGHEST LEVEL OF EDUCATION:

- [ ] No formal schooling
- [ ] Some primary school
- [ ] Primary school
- [ ] Some high school
- [x] Completed high school
- [ ] Some college
- [ ] Completed college
- [ ] Some university
- [ ] University degree

6. INCOME SOURCE:

- [x] Disability insurance (WSIB)
- [ ] Employment
- [ ] Employment insurance
- [ ] Family Support
- [ ] None
- [ ] ODSP
- [ ] Ontario Works
- [ ] Other Insurance
  Retirement
- [ ] Other _____

7. PARENTING (CUSTOM FIELD)

- [x] Yes, with 1 or more child aged 0-6 years
- [ ] Yes, with no children aged 0-6 years
- [ ] Children in care of others
- [ ] No children

SUBSTANCE USE & GAMBLING HISTORY

PRESENTING PROBLEM SUBSTANCES:

	SUBSTANCE USED	FREQUENCY IN LAST 30 DAYS- CHECKMARK ONE
MAJOR SUBSTANCE		☑ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly ☐ Daily ☐ Binge Age of 1st use: ☐ Age regular use began: ☐
1ST OTHER SUBSTANCE		☑ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly ☐ Daily ☐ Binge Age of 1st use: ☐ Age regular use began: ☐
2ND OTHER SUBSTANCE		☑ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly ☐ Daily ☐ Binge Age of 1st use: ☐ Age regular use began: ☐

OTHER SUBSTANCES USED IN PAST 12 MONTHS: (checkmark all the ones that apply) CHECK ALL UNCHECK ALL

- ☐ Alcohol
- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Cannabis
- ☐ Cocaine
- ☐ Crack
- ☐ Ecstasy
- ☐ Glue /Inhalants
- ☐ Hallucinogens
- ☐ Heroin\ Opium
- ☐ Methamphetamines (Crystal Meth)
- ☐ Other Psychoactive drugs
- ☐ Over-the-counter codeine products
- ☐ Prescription Opioids
- ☐ Steroids
- ☐ Tobacco
- ☐ Unknown
- ☐ None

GAMBLING ACTIVITIES ENGAGED IN THE PAST 12 MONTHS:

- ☐ Bingo - live/TV/radio
- ☐ Slot machines
- ☐ VLT's/ other gaming machines
- ☐ Casino- Card/Table Games
- ☐ Non-Casino Card/Table Games
- ☐ Horse races-live/off-track
- ☐ Sports betting (including Pro Line)
- ☐ Lottery tickets
- ☐ Instant win/scratch tickets (i.e. break open, pull tab, Nevada strips)
- ☐ Internet Gambling
- ☐ Gambling with Stocks/Options/Commodities/Real estate
- ☐ Betting on games of skill i.e. pool, pitching pennies
- ☐ Betting on the outcome of events
- ☐ Other _____
- ☐ None
- ☐ Unknown

IS GAMBLING IDENTIFIED AS A PROBLEM? ☐ **YES** ☐ **NO**

HEALTH STATUS/PROBLEMS

Visual impairment: **YES** ☐ **NO** ☑

Hearing impairment: **YES** ☐ **NO** ☑

Mobility/ physical impairment: **YES** ☐ **NO** ☑

Pregnant: **YES** ☐ **NO** ☐ **UNSURE** ☑

Non-medical intravenous drug use:
- ☐ Never injected
- ☐ Injected prior to one year
- ☑ Injected in last 12 months

Reason for most recent hospitalization: _____ Date: _____

Diagnosed with a mental health problem by a mental health professional:

-within the past 12 months- **YES** ☐ **NO** ☑

-within lifetime- **YES** ☐ **NO** ☑

-most recent diagnosis- _____

Hospitalized for a mental health problem?

-within the past 12 months- **YES** ☐ **NO** ☑

-within lifetime- **YES** ☐ **NO** ☑

Received counselling/support/treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

-currently- **YES** ☑ **NO** ☐

-within the past 12 months- **YES** ☐ **NO** ☑

-within lifetime- **YES** ☐ **NO** ☑

-name of current service provider: _____

-contact information for service provider: _____

HEALTH CONDITIONS

Please check all that apply:

[ ] Allergies- environmental- specify-_____
[ ] Allergies- food- specify _____
Does your allergy require an Epi-Pen?
Yes [ ] No [ ]
[ ] Blood pressure problems
[ ] Cancer
[ ] Chronic pain
[ ] Diabetes
[ ] Eating disorders (anorexia,bulimia, Over eating)
[ ] HIV/AIDS
[ ] Heart disease
[ ] Hepatitis A
[ ] Hepatitis B
[ ] Hepatitis C
[ ] History of head injuries/concussion
[ ] History of seizures/epilepsy
[ ] Jaundice
[ ] Kidney disease
[ ] Lice/scabies
[ ] Liver disease
[ ] Menstrual/menopausal difficulties
[ ] Pancreatitis
[ ] Respiratory
[ ] STD (syphilis, gonorrhea, chlamydia, herpes)
[ ] Stomach/gastrointestinal problems
[ ] Thyroid problems
[ ] Tuberculosis

Provider of Primary Health care (doctor, nurse practitioner, health clinic): _____

Contact information for provider of health care: _____

PRESCRIBED DRUGS

On Methadone or Suboxone: **YES [ ] NO [ ]** Prescriber:_____

Prescribed Drug	**Prescriber & Phone #**	**Prescription Details**

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING HEALTH STATUS:

REFERENTS COMPLETE:

REFERRAL INFORMATION:

1. What circumstances have made the client request treatment at this time?

2. What supports are you providing? How long have you been working with this client? Is therapy/counseling on going?

3. What supports does the client have access to in the community? What supports/services has the client accessed to date? (If the client has not accessed services please explain why)

TREATMENT HISTORY

1. Has the client previously tried to quit or cut down on their substance use or gambling?

No_____ Yes_____ How many times? _____

What were the circumstances that caused the client to make changes with his/her use during these times?

2. What has been the longest period of non-using? What did the client find helpful during those periods?

3. What do you identify as the reasons for returning to drinking/drug using/gambling?

4. What is the client's current substance use or gambling goal?

[ ] quit all substance use/gambling
[ ] maintain abstinence
[ ] other_____
[ ] cut down on _____
[ ] make no changes

OTHER POTENTIALLY EXCESSIVE BEHAVIOURS:
PLEASE CHECK THE BOXES BELOW IF THEY ARE RELEVANT. PROVIDE DETAILS IN THE SPACE PROVIDED. *Ie. Amount of time spent doing this activity, negative life impact, causes financial strain, topic of arguments with loved ones).*

☐ **NONE**

	☑	**DETAILS**
Shopping (excessive money spending)		
Internet overuse (surfing, chatting, blogging, social networking)		
Video Gaming (computer or home systems, online)		
Eating Disorder (starving on purpose, binging purging)		
Sex (pornography, excessive masturbating, visiting sex trade workers, preoccupation with sexual thoughts)		
Other		

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING EMOTIONAL HEALTH (INCLUDE ALL MENTAL HEALTH DIAGNOSIS DETAILS):

FAMILY/SUPPORTS

1. What community is the client originally from? _____

2. Childhood Experiences:

[ ] Substance abuse	[ ] Neglect
[ ] Witness to domestic violence	[ ] Divorce/separation of parents
[ ] Emotional, physical or sexual abuse	[ ] Death of a parent
[ ] Foster Care	[ ] Happy home life

3. How does the client describe the current relationship with his/her family of origin?

4. Relationship Experiences:

[ ] Never been in a relationship	[ ] Difficulties talking about feelings
[ ] Affairs	[ ] Violence/abuse
[ ] Mental health issues of partner	[ ] Solid/supportive relationship

5. If the client is currently in a relationship, does the partner struggle with any addiction issues? Please describe.

6. Does the client have any children? ☐ Yes ☑ No
If yes, who has custody of the children? What is the nature of the relationship with the children?

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING FAMILY, CHILDREN, AND SUPPORTS:

EMPLOYMENT / EDUCATION / LEGAL

1. Current or last occupation?_____

2. Does the client have EAP in the workplace?_____

3. Does the client have a history of learning disabilities or problems? YES [ ] NO [ ]
   If yes, what type:_____

4. Are there any literacy issues? YES [ ] NO [ ]

USE THIS SPACE TO PROVIDE MORE DETAIL ON EDUCATION & EMPLOYMENT:

LEGAL

1. Any current charges? YES [ ] NO [ ] When is the next court date?_____
2. If yes, are you on bail? YES [ ] NO [ ] What are the charges? _____
3. Are you on the Sex Offender Registry? YES [ ] NO [ ]
4. Do you have any no contact orders? YES [ ] NO [ ]
5. Have you, or are you currently banned from an emergency shelter? YES [ ] NO [ ]
6. If on probation or parole:
   What charges is the client on probation for?_____

   Probation or parole officer's name & contact info:_____

7. Past Offenses (check all that apply):

[ ] Theft / possession of stolen property
[ ] Drug charges
[ ] Weapons offenses
[ ] Robbery
[ ] Arson
[ ] Impaired driving
[ ] Parole / probation violations
[ ] Forgery
[ ] Burglary, break & enter
[ ] Assault
[ ] Sexual assault / incest
[ ] Willful damage / mischief
[ ] Murder / manslaughter, criminal negligence causing death
[ ] Other – (specify):_____

USE THIS SPACE TO PROVIDE MORE INFORMATION ON LEGAL:

_____ _____
Signature of Client Date

_____ _____
Signature of Counsellor Date