Chrysalis society

TEL: 604-325-0576 FAX: 604-325-0563
EMAIL: admin@chrysalissociety.com
HEAD OFFICE: #218 – 3369 Fraser Street
Vancouver, BC V5V 4C2

CLIENT NAME: LAST NAME, First Name

CLIENT DOB: Date / MONTH / Year
(must be 19+ years of age at intake)

NEW DAY RECOVERY HOME FOR WOMEN ~ REFERRAL

(to be completed by a Professional Referring Agent)

Referring Agent: ..... **Title/Role:** .....

Phone #: include extension # **Fax #:** ..... **Email:** .....

Agency/Program: ..... **Health Authority:** .....

PART 1 – General Information

Other / Preferred Names: Nicknames / Aliases

Cultural / Ethnic Identity: ..... **Indian Status:** Y ☐ N ☐ **Status #:** .....

Other Languages: ..... **Social Insurance #** Optional

Gender Identity: F ☐ Trans ☐ FTM ☐ MTF ☐ **MSP Care Card #** Optional

NFA ☐ **Housed** ☐ **Address (**☐ **mailing)** Suite #, Street Address, City, Postal Code

NOTE: MSD clients *must* discontinue rent-maintenance prior to admission; Chrysalis must receive verification from MSD that monthly room & board payments are available for the client before an admission to New Day or New Way can be scheduled.

Client's Home Phone: ..... **Messages Okayed:** Y ☐

Client's Cell Phone: ..... **Messages Okayed:** Y ☐

Client's Email ..... **Messages Okayed:** Y ☐

Client's Emergency Contact: Name & Relationship

Emergency Contact Home #: ..... **Emergency Contact Cell #:** .....

Dependent Child(ren)?
No ☐ Yes ☐ How Many: .....

☐ Living w/ client's parent(s)
☐ Living w/ separated spouse/partner
☐ Living w/ other family member(s)
☐ In foster-care
☐ MCFD involved

Employment Status:

☐ F/T Employed
☐ P/T Employed
☐ Unemployed
☐ Not in the Labour Force

Income:

☐ MSD (Income Assistance) ☐ Basic ☐ PPMB ☐ PWD
☐ Employment Insurance **EI Expiry Date:** .....
☐ Canadian Pension Plan **CPP – monthly amount:** .....
☐ EAP / Private Insurance **EAP / Ins. Carrier:** .....

Self-Pay: Y ☐ N ☐

Monthly Room & Board Rates at New Day & New Way are on a sliding scale ($500 - $2400). Self-Pay clients *must* provide an income/expenses outline prior to admission for assessment.

PART 2 – 2nd-Stage: Program Readiness

Date of Last DOC Use: ..... **Most recent completed 1st-stage Prgm:** Program & Completion Date

Other Licensed Recovery / Treatment Programs client has attended:

Program/Year: ..... **Outcome/Comments:** .....

Program/Year: ..... **Outcome/Comments:** .....

Program/Year: ..... **Outcome/Comments:** .....

Program/Year: ..... **Outcome/Comments:** .....

Program/Year: ..... **Outcome/Comments:** .....

What current indicators lead you to assess this client as being eligible and *emotionally ready* for 2nd-stage recovery programming & semi-independence within a communal-living environment?

What information can you provide regarding client's group role(s) and participation?

What information can you provide regarding active skills the client currently demonstrates in terms of emotional regulation, problem-solving & conflict-resolution?

Are there any challenges you've observed for this client within groups, or with regard to any of the above points (ie: emotional regulation, problem-solving, conflict-resolution and/or communal living)?

Please note relapse prevention strategies you and/or the client's primary support team have assisted her to develop and any other professional/peer supports/resources she has been supported to access (ie: Sponsor, Counsellor, Therapist, Program, etc.

PART 3 – Safety Concerns / Impacts of Violence

Domestic Violence (Family of Origin)	**Past ☐**	**Recent ☐**	**Current ☐**	**Never ☐**	**Unknown ☐**
Domestic Violence (in Relationships)	**Past ☐**	**Recent ☐**	**Current ☐**	**Never ☐**	**Unknown ☐**
Sexual Abuse/Assault (in Childhood/Adolescence)	**Past ☐**	**Recent ☐**	**Current ☐**	**Never ☐**	**Unknown ☐**
Sexual Abuse/Assault	**Past ☐**	**Recent ☐**	**Current ☐**	**Never ☐**	**Unknown ☐**
Other Violence: _____	**Past ☐**	**Recent ☐**	**Current ☐**	**Never ☐**	**Unknown ☐**
Client has been violent with others: _____	**Past ☐**	**Recent ☐**	**Current ☐**	**Never ☐**	**Unknown ☐**

Current Restraining / No Contact Order(s) : No ☐ Yes ☐ Required ☐ **Victims Services Involvement: No ☐ Yes ☐ Required ☐**

Please provide any other information relevant to current safety concerns or any current or ongoing impacts violence has on this client's current recovery processes: _____

_____

_____

_____

_____

PART 3 – Mental Health / Medications

Mental Health

_____	**Diagnosed ☐**	**Never Assessed ☐**	**Suspected ☐**	**Assessment Recommended ☐**
_____	**Diagnosed ☐**	**Never Assessed ☐**	**Suspected ☐**	**Assessment Recommended ☐**
_____	**Diagnosed ☐**	**Never Assessed ☐**	**Suspected ☐**	**Assessment Recommended ☐**
_____	**Diagnosed ☐**	**Never Assessed ☐**	**Suspected ☐**	**Assessment Recommended ☐**
_____	**Diagnosed ☐**	**Never Assessed ☐**	**Suspected ☐**	**Assessment Recommended ☐**

Disordered Eating:

Anorexia: **Diagnosed ☐** **Never Assessed ☐** **Suspected ☐** **Assessment Recommended ☐**

☐ Restriction **Past ☐** **Recent ☐** **Never ☐** **Current ☐**

☐ Over-Exercise **Past ☐** **Recent ☐** **Never ☐** **Current ☐**

Bulimia: **Diagnosed ☐** **Never Assessed ☐** **Suspected ☐** **Assessment Recommended ☐**

☐ Purging **Past ☐** **Recent ☐** **Never ☐** **Current ☐**

☐ Laxative Misuse **Past ☐** **Recent ☐** **Never ☐** **Current ☐**

Suicidality / Self-Harm:

Suicidality: **Past ☐** **Recent ☐** **Never ☐** **Current ☐** **Comments:** most recent incident dates(s), etc.

Attempt(s): **Past ☐** **Recent ☐** **Never ☐** **Current ☐**

Ideation: **Past ☐** **Recent ☐** **Never ☐** **Current ☐**

Self-Harm: **Past ☐** **Recent ☐** **Never ☐** **Current ☐** **Comments:** most recent incident dates(s), etc.

Incident(s): _____

Ideation: _____

Recent Hospitalizations: _____

_____

Medications:

MEDICATION	CURRENT DOSAGE	CONDITION TREATED	TAKEN FOR HOW LONG

Prescribing Physician: ..... **Practice:** GP or Psych. .....

Phone #: include extension # ..... **Fax #:** ..... **Email:** .....

Clinic/Program: ..... **Health Authority:** .....

Current Opiate Replacement Therapy:

☐ **Methadone** ..... **mg** **Taken since** ..... **Comments:** .....

☐ **Methadose** ..... **mg** **Taken since** ....

☐ **Suboxone** ..... **mg** **Taken since** ....

Addictions Physician: ..... **Title/Role:** .....

Phone #: include extension # ..... **Fax #:** ..... **Email:** .....

Clinic/Program: ..... **Health Authority:** .....

Please provide any other information or concerns relevant to the client's medications: .....

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PART 3 – Medical Health

SIGNIFICANT MEDICAL CONDITIONS

☐ Acquired Brain Injury
☐ Degenerative Disc Disease
☐ Chronic Pain
☐ Dental Problems
☐ Fetal Alcohol Spectrum Disorder
☐ Other Medical Conditions: .....

COMMUNICABLE INFECTIONS

☐ HIV ☐ MRSA: Medical Clearance required if MRSA has been active w/in 12 months
☐ HEP-C ☐ TB: Date of last test: ..... ☐ TB Positive ☐ TB Negative

ALLERGIES (Medications, Food, Environmental)

.....
.....

Special Needs / Challenges: .....
Special Aid(s) Used / Required: .....
Special Dietary Needs: .....

PART 4 – Problematic Substance Use/Misuse History

Substance (check all that apply)	Method (Oral, Smoke, Snort, Intravenous, Intramuscular)	Frequency of Use (Daily, Regularly, Occasionally)	# of Years of Problematic Use	Date of Last Use
☐ Alcohol				
☐ Barbiturates				
☐ Benzodiazepines (illicit)				
☐ Benzodiazepines (prescribed)				
☐ Cocaine				
☐ Club Drugs (GHB, Ketamine)				
☐ Crack Cocaine				
☐ Crystal Meth				
☐ Ecstasy / MDMA				
☐ Hallucinogens				
☐ Heroin				
☐ Inhalants				
☐ Methadone / Methadose (illicit)				
☐ Nicotine / Tobacco				
☐ Opiates (illicit, other than Heroin or Methadone)				
☐ Opiates (prescribed, other than Heroin or Methadone)				
☐ Other Prescription Meds Misuse:				
☐ Other:				

Current Risk of Relapse: ☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High

Comments: .....

Other Problematic Addiction(s) / Behaviour(s) (☐ Not Applicable)

Addiction / Behaviour (check all that apply)	Frequency of Engagement	Date of Last Engagement	# of Years of Problematic Engagement	Current Stage of Change
☐ Electronics / Internet				
☐ Gambling				
☐ Hoarding				
☐ Pornography				
☐ Relationships				
☐ Sex				
☐ Shopping / Spending				
☐ Stealing / Theft				
☐ Other:				
☐ Other:				

Primary Problematic Behaviour(s): .....

Longest Abstinence Achieved: .....

Current Risk of Relapse: ☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High

Comments: .....

.....

PART 5 – History of Other Peer/Community-Based Resource/Program(s) Accessed

Resource / Group Accessed	In Benefit of what Aspect of Client's Wellness	Accessed When ([Past/Year] or [Present])	Any Relevant Outcomes

Any other Comments re: client's history of accessing other Peer/Community-Based Resource/Program(s): .....

.....

.....

.....

.....

.....

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CLIENT AUTHORIZATION: My signature below verifies that the information I have provided to the Referring Agent noted below for the purposes of this referral and my application for residence within Chrysalis Society's program(s) is accurate to the best of my knowledge. My signature also authorizes the release and/or exchange of information between Chrysalis Society Staff and all service providers noted below. This authorization is valid for pre-admission and collaboration of care purposes, and for the entire duration of my residence within New Day and/or New Way Recovery Homes for Women, and at no other time.

....
Client Signature **Date**

.

REFERRING AGENT IDENTIFICATION/VERIFICATION: ....
Print Name **Agency / Organization**

....
Referring Agent Signature **Date**

SERVICE PROVIDER	NAME	AGENCY / ORGANIZATION	TELEPHONE # (include extensions)	FAX # or EMAIL
Addictions Counsellor				
Other Counsellor				
Physician (GP)				
Addictions Physician				
Psychiatrist				
Clinical Therapist				
Mental Health Worker				
Housing Worker				
Probation/Parole Officer				
Lawyer				
MCFD Social Worker				
Victims Services Worker				
EAP Claims Representative				
Insurance Representative				
Other Service Provider				
Other Service Provider				
Other Support Provider				
Other Support Provider				

Chrysalis society

MSD INCOME VERIFICATION FOR 2ND-STAGE APPLICANTS

TO: MSD Office: client's Home MSD Office **FAX:** .....

FROM: Chrysalis Society **FAX:** 604-325-0563

RE: CLIENT: ..... **SIN #:** .....

INCOME SOURCE	MONTHLY TOTAL(S)
MSD ☐ ETW ☐ PPMB ☐ PWD	$
ADS Subsidy Funding	$
EI Insurance	$
CPP Insurance	$
Employee Assistance Program	$
Self/Family Pay	$
Other:	$
TOTAL INCOME FROM ALL SOURCES →	**$**

I certify that the above information is true to the best of my knowledge. I understand that the information I have provided will be used only for the income verification necessary for my residency in Chrysalis Society's above-noted recovery home. My signature below authorizes Chrysalis Society to contact the above-listed income source(s) for verification purposes.

....

Client Signature **Date**

★★★MSD OFFICE USE ONLY★★★

MINISTRY OF HOUSING & SOCIAL DEVELOPMENT: COMPLETE & RETURN THIS SECTION VIA FAX

This client has an active and open file: ☐ NO ☐ YES: ☐ ETW ☐ PPMB ☐ PWD

Applicable Exemptions / Other Income: ☐ CPP: $ ..... /month
☐ FMEP: $ ..... /month
☐ Other: $ ..... /month

This client has pending deduction(s) from recent employment that will affect her IA in the near future: ☐ NO ☐ YES

IF YES, this amount: $ ..... will be deducted for this/these months: .....

This client is currently having shelter costs maintained: ☐ YES ☐ NO

This client will have available room & board funds upon admission: ☐ YES ☐ NO

Additional Comments: .....
.....
.....

PLACE OFFICE STAMP HERE →

Completed by:

Signature: .....

Date: .....