



Island Health Mental Health and Substance Use – Regional Substance Use Treatment Programs

Referral Package

Referral Process

1. Referral agents forward the completed referral package to the Regional Treatment Beds Team by fax to 250-519-1896.
2. The Regional Treatment Beds Team will screen the referral for completeness
 - a. If an incomplete referral is received, the referral agent will be notified by email to provide the missing information and resubmit a complete referral by fax.
3. If deemed complete, the referral is sent to the Regional Triage Committee for review. The Committee will review the referral within one to two weeks.
4. The accepted referrals will be sent to the appropriate site to be added to the waitlist.
5. The designated site will contact the referral agent of the referral acceptance and provide a wait time estimate.
6. When a bed is available, the referral agent and participant will be contacted to plan intake.

If a referral is not accepted, the referral agent will be notified by email and provided with a list of available resources and the process for appealing the decision.

Referral package completion checklist

Please note:

- This package is intended to be completed by a community support team member or a health care professional, in collaboration with the participant. A referring agent can include a counsellor, social worker, physician, psychiatrist, community health team member, psychologist, nurse practitioner, and/or case manager.
- It is preferred that the referral package is completed electronically with page 12 and 13 physically signed. We do not accept verbal consent or electronic signatures.

Before submitting to the Regional Triage Committee for processing, please ensure the following tasks are complete:

- Complete the included referral form, fill in all applicable boxes
- Complete the Release of Information Form for contracted sites (Edgewood Health Centre, Cedars at Cobble Hill) on page 13.
- Include the following collateral information if available and applicable:
 - Current and recent psychiatric and/or medical consults
 - Hospital admission/discharge notes
 - Relevant discharge summaries
 - Forensic assessments (if applicable)
 - Current MAR or list of medications
 - Probation/Bail orders
- Current Mental Health certificates (if applicable)
- In consultation with the participant, complete and attach the Early Exit Transition Plan form
- In consultation with the participant, complete and attach Participant Agreement for the appropriate program. Please ensure that it is signed.
- Review program specific participant guide with the participant.
- Ensure participant is successfully registered with British Columbia MSP.
- For clients being referred from the South Island, please complete the addendum questions on page 15.

The above components constitute a complete referral and will be reviewed by the programs' Regional Triage Committee once received. Additional information to about each site's participant selection criteria can be found on pages 15 and 16.

If you are having problems acquiring or completing the required information and would like support, please contact treatmentcentres@islandhealth.ca to be directed to the proper site contact for further clarification.

Referral Form

Select program:	<input type="checkbox"/> Coastal Sage Healing House <input type="checkbox"/> Edgewood Health Centre	
	<input type="checkbox"/> Cedars at Cobble Hill 	
Participant's Referral Information		
Referral Date: (DD/MM/YYYY)		
Participant's Legal Name:		Preferred Name(s):
Referring agent's contact name:		
If referring agent is hospital, name of hospital & unit:		
Referring organization:		
Ph:	Fax:	Email:
Community Care Team Information		
MHSU Care Team Name:		
MHSU Care Team Contact Name:	Email:	Ph:
Family Physician Name:	Fax:	Ph:
Psychiatrist Name:	Fax:	Ph:
Community Pharmacy:	Fax:	Ph:
Client Information		
Date of Birth: (DD/MM/YYYY)	Age:	PHN:
Gender Identity: (tick all that apply)	<input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary	
	<input type="checkbox"/> Male <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Questioning	
	<input type="checkbox"/> My Gender Identity is _____ <input type="checkbox"/> Prefer not to answer	
Pronoun: (tick all that apply)	<input type="checkbox"/> She <input type="checkbox"/> He <input type="checkbox"/> They <input type="checkbox"/> My pronoun is _____	
Current Address:	City:	
Province:	Postal Code:	Ph:
		Email:
Income Information: (tick all that apply)	<input type="checkbox"/> PPMB <input type="checkbox"/> Hardship Assistance <input type="checkbox"/> IA <input type="checkbox"/> PWD <input type="checkbox"/> Medical EI <input type="checkbox"/> EI <input type="checkbox"/> Employment <input type="checkbox"/> No income <input type="checkbox"/> Pension and/or CPP <input type="checkbox"/> Old Age Security (OAS) <input type="checkbox"/> Survivors Benefits <input type="checkbox"/> Private Benefits <input type="checkbox"/> Other: _____	
Medical/Pharmacy Coverage		
Registered with BC MSP:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of medical/pharmacy coverage:		Third Party Insurer:

Policy #:		ID #:	
Cultural Information			
Does the participant identify as an Indigenous Person?	<input type="checkbox"/> Indigenous <input type="checkbox"/> Non-Indigenous <input type="checkbox"/> Unknown	<input type="checkbox"/> Participant declined, ask again later <input type="checkbox"/> Participant declined, do not ask again <input type="checkbox"/> Prefer not to answer	
Predominantly lives:	<input type="checkbox"/> On reserve <input type="checkbox"/> Both on & off reserve	<input type="checkbox"/> Off reserve	
First Nations Status:	<input type="checkbox"/> Has status <input type="checkbox"/> Pending Status	<input type="checkbox"/> Non Status	
Status card #:		Band:	
Primary Language(s):		Interpreter needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide details of language interpretation needs:			
We invite the participant to let us know if there are any spiritual, religious practices or ceremonies that will support their wellness while in treatment: (please describe below)			
Emergency Contact Person (Family/Friend/Support Person)			
<i>(Please note that the person below will be contacted should there be an emergent concern about safety, wellbeing, medical emergencies, etc.)</i>			
Name (first & last):		Relationship:	
Phone:		Email:	
Is there a power of attorney in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, name:		Ph:	
Family Involvement			
Does the participant have children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# of children:	Age of children:
If child(ren), what is current living situation?			
If applicable, what visits are available for the participant with their child(ren)?			
Are there family members or friends that are important to the participant that they would like involved as part of their treatment planning or aftercare planning?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details below:			
Is there Ministry of Children and Family Development involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Current Housing							
Housing Type:	<input type="checkbox"/> Own home	<input type="checkbox"/> Shelter	Stable:	<input type="checkbox"/> Yes	Safe:	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No fixed address	<input type="checkbox"/> With family/friends		<input type="checkbox"/> No		<input type="checkbox"/> No	
	<input type="checkbox"/> Subsidized housing	<input type="checkbox"/> Rental				<input type="checkbox"/> No	
	<input type="checkbox"/> Other: _____						
Will housing be maintained for the duration of treatment?			<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If no, provide details:							
Is there a post-discharge housing plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe actions taken to address post-discharge housing:					
Participant Strengths							
Treatment Goals							
How can staff best support participants to achieve their treatment goals?							
Is there any additional information that should be provided at this time?							
Substance Use and other process issues/concerns							
Participant has used/ a history with	Current Pattern (i.e. Daily, Binge)	Date last used	# Days used in last 30 days	Route taken	Average amount used daily	Age at first use	
<input type="checkbox"/> Alcohol							
<input type="checkbox"/> Non-beverage alcohol							
<input type="checkbox"/> Amphetamines							
<input type="checkbox"/> Ecstasy							
<input type="checkbox"/> GHB							
<input type="checkbox"/> Benzo							

<input type="checkbox"/>	Cannabis						
<input type="checkbox"/>	Cocaine						
<input type="checkbox"/>	Crack cocaine						
<input type="checkbox"/>	Crystal Meth						
<input type="checkbox"/>	Fentanyl						
<input type="checkbox"/>	Hallucinogens						
<input type="checkbox"/>	Heroin						
<input type="checkbox"/>	Inhalants						
<input type="checkbox"/>	Other opioids						
<input type="checkbox"/>	Tobacco/ Nicotine (incl. vaping/e-cigs)						
<input type="checkbox"/>	Other (specify): _____						

Process Addictions

Participant has current/history with	Current Pattern	Date last active (D/M/Y)	# Days active last 30 days	Age at first use
<input type="checkbox"/>	Gambling			
<input type="checkbox"/>	Sexual activity			
<input type="checkbox"/>	Pornography			
<input type="checkbox"/>	Shopping			
<input type="checkbox"/>	Shoplifting			
<input type="checkbox"/>	Internet			
<input type="checkbox"/>	Gaming			
<input type="checkbox"/>	Social Media			
<input type="checkbox"/>	Other (specify): _____			

Substance Use Treatment History

<input type="checkbox"/>	Withdrawal Management/Detox/Stabilization	Dates:	
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<input type="checkbox"/>	Peer Support Groups (AA/NA/Smart Recovery/etc.)	Dates:	
<input type="checkbox"/>	Community counsellor/social worker support	Dates:	
<input type="checkbox"/>	Supportive Recovery	Dates:	
<input type="checkbox"/>	Substance Use Treatment Programs (provide details below):		
Program:		Date range:	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Program:		Date range:	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Program:		Date range:	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
For any programs not completed, please provide details below:			
Why is this program being considered at this time?			
Withdrawal History			
Withdrawal management prior to admission needed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of adverse events while in withdrawal (e.g. seizures):		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last seizure:
Medically confirmed Delirium Tremens?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital admissions for withdrawal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide any other information that the participant feels would be relevant to support them below:			
Medical History			
Environmental, food, medication allergies?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide a brief description, type of reaction(s) and treatment needed:			

Pregnant or post-partum?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Provide (estimated) date of delivery and other key details:	
Past overdose history?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: <input type="checkbox"/> Intentional <input type="checkbox"/> Accidental	Date(s):
History of disordered eating?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is disordered eating still active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details on what accommodation will be required during treatment:			
Medical dietary concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the participant have any dietary requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please note concerns and requirements here:			
Independent with Activities of Daily Living (ADLs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, provide details:	
Mobility issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe mobility challenge and what, if any, ability aids are being used and/or are needed below:	
Fall risk:	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Visual impairment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing impairment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head injury:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes to any of the above, please provide details:			
If yes to visual and or hearing impairment, please describe the challenge and what, if any, aids are being used and/or are needed below:			

Safety Concerns					
Self-harming behaviours?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide ideation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flight risk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex work involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual offences involving minors?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Arson/Fire setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interpersonal/Domestic violence?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes to any of the above, please provide detailed information about the safety concern and if possible, provide a copy of the safety plan. Please include the date and circumstances of the most recent incident for each concern.</i>					
History of aggression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <input type="checkbox"/> Verbal <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Other/Unknown			
<i>Please provide a brief description of history of verbal and/or physical aggression incidents, outcomes and date of last occurrence (e.g. throwing objects, hitting someone, yelling, under the influence of substances).</i>					
<i>Please list effective interventions here, or attach a behaviour care plan/safety plan if there is one in place:</i>					
Legal Information					
Is the participant supervised by a probation officer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the participant currently out on bail?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bail/Probation Officer's contact name:		Ph:			
Can the participant be supported in program in reference to recent/past charges?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any conditions that we need to be aware of to support the participant's stay?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide details needed to support participant's stay:					
Upcoming court date(s) and location:					
<i>Please provide details (e.g. transportation required, technological requirements, etc.):</i>					
Status under the BC Mental Health Act:	<input type="checkbox"/> Certified <input type="checkbox"/> Voluntary <input type="checkbox"/> Extended Leave – Please attach all Forms 4, 6, & 20				

Safe Exit Plan

A safe exit is when a participant leaves treatment prior to treatment completion. In this event, our goal is for the participant to have a safe place to go in their home community with appropriate supports. If the participant leaves on short notice, or an unplanned urgent discharge is required, the MHSU Community Care Team Contact and the Emergency Contact will be notified immediately, and the participant will be discharged to the location listed below.

The plans below must be realistic and actionable within a short timeframe (e.g. 4-6 hours).

Participant Name:			
Key community contact for transition plan (name & relationship):			
Ph:		Email:	
Emergency contact and/or next of kin (name & relationship):			
Ph:		Email:	
MHSU Community Care Team Contact (name & organization/team)			
Ph:		Email:	

Safe Exit Discharge Plan – Plan A

Safe exit location contact name:		Relationship:	
Safe exit location address:		Location Ph:	
If safe exit is home with family, are they aware?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe exit transportation:			
If no, who will transport? (name, phone, relationship)			
Is this safe exit plan the same for the weekend?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please provide alternative plan below:	

Safe Exit Discharge Plan – Plan B (Safe Exit due to Relapse)

Safe exit location contact name:		Relationship:	
Safe exit location address:		Location Ph:	
If safe exit is home with family, are there aware?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe exit transportation:			
If no, who will transport? (name, phone, relationship)			

Is this safe exit plan the same for the weekend?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please provide alternative plan below:	
Signatures			
By signing below, I consent to the following:			
<ul style="list-style-type: none"> • This referral is being submitted for consideration for an Island Health Regional Substance Use Treatment Program • The information in this referral and any supporting documentation being released and shared between my community care team, regional health authority representatives, Island Health Regional Substance Use Treatment Program representatives is correct to the best of my knowledge • Should I choose to leave the program early, my community care team, Island Health Regional Substance Use Treatment Program representatives and my emergency contact will be contacted and provided with an update • My community team will be sent a discharge summary • Signatures must be provided as written consent. 			
Participant name (Print):			
Participant signature:		Date: (D/M/Y)	
<i>Referral agent agrees to collaborate with the participant to ensure they reconnect with their community services upon discharge.</i>			
Referral agent name (Print):			
Referral agent signature:		Date: (D/M/Y)	

Release of Information Form

Consent to Sharing of Personal Information	
<ul style="list-style-type: none"> • This consent is in regard to my referral to the treatment beds contracted by Island Health at Edgewood Treatment Centre and Cedars at Cobble Hill (the “contracted service providers”). • I consent to my care team, including Island Health representatives and the contracted service providers sharing my relevant health information to support quality and continuity of care. • I confirm that the information in this referral and any supporting documentation being released and shared between my community care team, Island Health representative and the contracted service providers is correct to the best of my knowledge. • Should I choose to leave the program early, my community care team and the Island Health liaison will be notified. • Signatures must be provided as written consent. 	
Client Name:	<i>Referring Clinician agrees to collaborate with the client and service provider as required during and after participation in the contracted treatment program.</i>
Client Date of Birth:	
Date Signed:	Date Signed:
Client Signature:	Referring Clinician Signature:

Addendum for South Island Clients – Housing Overdose Prevention Services (HOPPS) Involvement

HOPPS are rooms in supportive housing facilities where residents of those buildings can go to use substances. The primary goal is to provide a space for people to inject previously obtained illicit drugs, with sterile equipment, in a setting where trained staff/resident responders can check-in, observe, and intervene in overdose situations as needed. The purpose of these questions is to enhance the understanding of HOPPS service usage, and to help plan for future service delivery.

Is the client living in a site where a HOPPS program is provided?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If yes, which supportive housing site?	<input type="checkbox"/> Tally Ho Apartments <input type="checkbox"/> Queens St. Apartments <input type="checkbox"/> Albina <input type="checkbox"/> Tiny Town <input type="checkbox"/> Muncey Place <input type="checkbox"/> Capital City Centre (CCC) <input type="checkbox"/> Le Soleil <input type="checkbox"/> Mt. Tolmie <input type="checkbox"/> Juniper <input type="checkbox"/> Johnson St. Apartments <input type="checkbox"/> Tillicum Apartments <input type="checkbox"/> Spaken House <input type="checkbox"/> Lighthouse <input type="checkbox"/> House of Courage (Catherine St.) <input type="checkbox"/> Other _____	
Is the client engaged in any HOPPS service provision either at their supportive housing site or another supportive housing site (i.e. use of safe injection space, use of safe inhalation space, and/or engagement with HOPPS staff and/or resident responder for witnessed consumption)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If known, which safe consumption contractor is being used?	<input type="checkbox"/> SOLID <input type="checkbox"/> Peers <input type="checkbox"/> Umbrella <input type="checkbox"/> AVI <input type="checkbox"/> Unknown	

Participant Selection Criteria

In order to help determine which program is most suitable for your client, the following table outlines the appropriateness criteria for each program.

Selection Criteria	Coastal Sage Healing House	Edgewood Health Centre	Cedars at Cobble Hill
Program Mandate	Moderate to severe substance use disorder. Participants may or may not have a stable co-occurring mild to moderate mental health disorder. Participants are voluntary. Participants require a woman-only environment.	Moderate to severe substance use disorder. Participants may or may not have a stable mild to moderate co-occurring mental health disorder. Participants are voluntary.	Moderate to severe substance use disorder. Participants may or may not have a stable mild to moderate co-occurring mental health disorder. Participants are voluntary.
Specialization	People who identify as women & non-binary individuals	General substance use challenges	General substance use challenges
Length of stay	90 Days	50 Days	90 Days
Island Health Resident	✓	✓	✓
Age	19+	19+	19+
Gender Identity	People who identify as women & non-binary individuals	Individuals of all genders and orientations	Individuals of all genders and orientations
Medically, Behaviorally and Psychiatrically Stable	✓	✓	✓
Independent Activities of Daily Living:	✓ (Will provide set-up support)	✓	✓
MHSU or Community Care Team Connection	✓	✓	✓
Offers involuntary treatment (exceptions for Extended Leave or voluntary choice of treatment through Integrated Court or First Nations Court)	X	X	X
Offers on-site withdrawal management	X	✓	✓

Supports pregnant or immediately post-partum participants	Yes, prior to 3 rd trimester	✓	✓
Supports process addictions	✓	✓	✓

Additional Considerations	Exclusion Criteria	Program Discharge Criteria
<i>The following will also be considered when assessing participants for appropriate treatment match and timing:</i>	<i>Please contact the site representatives noted on page 2 if unsure about exclusion criteria</i>	<i>Requests regarding early transitions/discharge from treatment program may include the following:</i>
Significant mobility challenges	Does not offer involuntary treatment.	Physical, sexual or verbal threats/ abuse/violence.
A recent and/or significant history of physical violence.	Sexual offences involving minors are considered on a case-by-case basis.	Participant's presentation or symptom severity requires care/ treatment in acute care/other tertiary facility.
Acute suicidality and ideation.	Arson/Fire setting are considered on a case-by-case basis.	Persistent pattern of alcohol or drug use and not engaging in safety or relapse prevention plans.
To ensure safety for all, participant mix and site milieu will be considered	Severe violence including sexual violence is considered on a case-by-case basis.	Attempted/recruitment of others into gangs or sex trade.
	Significant safety risk to themselves or others.	Recruiting others into illegal or harmful activities.
	Unable to support participants with neurocognitive disorders, dementia, and/or Alzheimer's diagnosis preventing their capacity to participate in programming.	Drug dealing/sharing. Persistent pattern of non-participation in programming.