Island Health Addiction Medicine and Substance Use - Regional Treatment Beds Program
External 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.

For service provider use to refer individuals for bed-based substance use treatment centres. For current, up-to-date treatment centre information, please refer to the website

Regional Treatment Beds Program | Island Health

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.
- Please ensure the referral package is completed in full and includes physical signatures where required. Verbal consent and electronic signatures are not accepted.

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 treatment centres on page 15.

☐ Include the following collateral information if available and applicable:

- Current and recent psychiatric and/or medical consults
- Recent 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, ensure the safe discharge plan aligns with the Island Health Safe Exit Guideline.

☐ Review program specific participant guide with the participant.

☐ Ensure participant is successfully registered with British Columbia MSP.

The above components constitute a complete referral and will be reviewed by the programs' Regional Triage Committee once received. Additional information about each site's participant selection criteria can be found on pages 19 and 20.

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 your preferred treatment centre region:	☐ South Island ☐ Central Island				
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 Accepted participants are required to maintain ongoing engagement with their referral team in order to remain on the waitlist. If the referral team is unable to provide ongoing longitudinal care, please refer the participant to the After Care Clinician (ACC) program. The ACC referral form can be found on pages 16-18 of this referral package.					
MHSU Care Team Name:					
MHSU Care Team Contact Name:		Email:		Ph:	
Primary Care Provider:		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)	☐ Female ☐ Male ☐ My Gender Identity is _____	☐ Transgender ☐ Two-Spirit	☐ Non-Binary ☐ Questioning ☐ Prefer not to answer		
Pronoun: (tick all that apply)	☐ She ☐ He ☐ They ☐ My pronoun is _____				
Current Address:		City:			
Province:		Postal Code:		Ph:	Email:
Income Information: (tick all that apply)	☐ PPMB ☐ Hardship Assistance ☐ IA ☐ PWD ☐ Medical EI ☐ EI				

	☐ Employment ☐ No income ☐ Pension and/or CPP ☐ Old Age Security (OAS) ☐ Survivors Benefits ☐ Private Benefits ☐:_____

Medical/Pharmacy Coverage			
Registered with BC MSP:	☐ Yes ☐ No		
Type of medical/ pharmacy coverage:		Third Party Insurer:	
Policy #:		ID #:	

Cultural Information		
Does the participant identify as an Indigenous Person?	☐ Indigenous ☐ Non-Indigenous ☐ Unknown	☐ Participant declined, ask again later ☐ Participant declined, do not ask again ☐ Prefer not to answer
Predominantly lives:	☐ On reserve ☐ Both on & off reserve	☐ Off reserve
First Nations Status:	☐ Has status ☐ Pending Status	☐ Non-Status

Status card #:		Band:	
Primary Language(s):		Interpreter needed?	☐ Yes ☐ 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) *(Please note that the person below will be contacted should there be an emergent concern about safety, wellbeing, medical emergencies, etc.)*			
Name (first & last):		Relationship:	
Phone:		Email:	
Is there a power of attorney in place?	☐Yes ☐ No		
If yes, name:		Ph:	

Family Involvement					
Does the participant have children?	☐ Yes ☐ 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?				☐ Yes ☐ No	
If yes, please provide details below:					
Is there Ministry of Children and Family Development involvement?				☐ Yes ☐ No	

Current Housing				
Housing Type:	☐ Own home ☐ Shelter ☐ No fixed address ☐ With family/friends ☐ Subsidized housing ☐ Rental ☐ Other: _____	Stable:	☐ Yes ☐ No	Safe: ☐ Yes ☐ No
Will housing be maintained for the duration of treatment?		☐ Yes ☐ No		
If no, provide details:				
Is there a post-discharge housing plan?	☐ Yes ☐ 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

If the participant is currently abstinent, please provide frequency and amount used prior to abstinence date.

Participant has used/ a history with		Current frequency (i.e. daily, weekly, monthly, etc.)	Date last used	# Days used in last 30 days	Route taken	Average amount used daily
☐	Alcohol					
☐	Non-beverage alcohol					
☐	Amphetamines					
☐	Ecstasy					
☐	GHB					
☐	Benzo					
☐	Cannabis					
☐	Cocaine					
☐	Crack cocaine					
☐	Crystal Meth					
☐	Fentanyl					
☐	Hallucinogens					
☐	Heroin					
☐	Inhalants					
☐	Other opioids					
☐	Tobacco/ Nicotine (incl. vaping/e-cigs)					
☐	Other (specify): _____					

Process Addictions				
Participant has current/history with		Current Pattern	Date last active (D/M/Y)	# Days active last 30 days
☐	Gambling			
☐	Sexual activity			
☐	Pornography			
☐	Shopping			
☐	Shoplifting			
☐	Internet			
☐	Gaming			
☐	Social Media			
☐	Other (specify): _____			

Substance Use Treatment History

All participants are required to have previously accessed lower levels of substance use treatment in order to be eligible for this funding.

☐	Detox/Stabilization	Dates:	
☐	Peer Support Groups (AA/NA/Smart Recovery/etc.)	Dates:	
☐	Community Counsellor/Social Worker Support	Dates:	
☐	Virtual Substance Use Services	Date:	
☐	Supportive Recovery	Dates:	

☐	Substance Use Treatment Programs (provide details below): If a Substance Use Treatment Program is checked off as not completed, please provide more information as to why this is the case below.

Program:		Date range:		Completed: ☐ Yes ☐ No
Program:		Date range:		Completed: ☐ Yes ☐ No
Program:		Date range:		Completed: ☐ Yes ☐ No

For any programs not completed, please provide details below:

Why are Regional Treatment Beds being considered at this time?

Withdrawal History

Is Medical Detox needed prior to admission?	☐ Yes ☐ No		
History of adverse events while in withdrawal (e.g. seizures):	☐ Yes ☐ No	Date of last seizure:	
Medically confirmed Delirium Tremens?	☐ Yes ☐ No	Hospital admissions for withdrawal?	☐ Yes ☐ No

Please provide any other information that the participant feels would be relevant to support them below:

Medical History							
Environmental or medication allergies?		☐ Yes ☐ No					
If yes, please provide a brief description, type of reaction(s) and treatment needed:							
Pregnant or post-partum?	☐Yes ☐ No	Provide (estimated) date of delivery and other key details:					
Past overdose history?	☐ Yes ☐ No	If yes: ☐ Intentional ☐ Accidental		Date(s):			
History of disordered eating?		☐ Yes ☐ No	Is disordered eating still active?		☐ Yes ☐ No		
If yes, provide details on what accommodation will be required during treatment:							
Medical dietary concerns?	☐ Yes ☐ No	Does the participant have any dietary requirements or allergies?			☐ Yes ☐ No		
Please note concerns and requirements here:							
Independent with Activities of Daily Living (ADLs)?		☐ Yes ☐ No	If no, provide details:				
Mobility issues?	☐ Yes ☐ No	If yes, please describe mobility challenge and what, if any, ability aids are being used and/or are needed below:					
Fall risk:	☐ Yes ☐ No	HIV:	☐ Yes ☐ No ☐ Unknown		Hep C:	☐ Yes ☐ No ☐ Unknown	
Visual impairment:	☐ Yes ☐ No	Prosthesis:	☐ Yes ☐ No	Head injury:	☐ Yes ☐ No ☐ Unknown		
Hearing impairment:	☐ Yes ☐ No	Complex cognitive challenges:			☐ Yes ☐ No ☐ Unknown		
Other:							

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:

Mental Health History

If the following sections do not apply to participant, please write N/A

Psychiatric diagnoses (Axis I):

Personality disorders & development disabilities (Axis II):
Note: for head/brain injury/FASD or cognitive impairment provide a brief description of cognitive disabilities & attach any collateral assessments/reports.

Medical Health History:

Psychosocial and environmental concerns:

Is participant connected to Community Living BC?			☐ Yes ☐ No
Contact Person:		Ph:	

Current Medication(s)

Please attach a list of medication such as a Pharmanet print-out, copy of prescriptions, Medication Administration Record (MAR) or write the information below

Is participant currently taking any medications? ☐ Yes ☐ No

Medication & Dose	Date Started (D/M/Y)	Prescriber	Medication & Dose	Date Started (D/M/Y)	Prescriber

Currently on ARV treatment?	☐ Yes ☐ No	Have ARV medications been ordered for treatment?	☐ Yes ☐ No
Currently on long-acting injectable antipsychotic medication?	☐ Yes ☐ No	Date of next required dose: (D/M/Y)	

Safety Concerns

Self-harming behaviours?	☐ Yes ☐ No	Suicide ideation?	☐ Yes ☐ No	Flight risk?	☐ Yes ☐ No

Sexual offences involving minors? ☐ Yes ☐ No

Arson/Fire setting?	☐ Yes ☐ No	Interpersonal/Domestic violence?	☐ Yes ☐ No

If yes to any of the above, please provide detailed information regarding the most recent concern(s), including the date and circumstances of the incident(s), and attach a current safety plan.

History of aggression?	☐ Yes ☐ No	If yes, ☐ Verbal ☐ Physical ☐ Sexual ☐ Other/Unknown

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).

Please list effective interventions here, or attach a behaviour care plan/safety plan:			
Legal Information If participant has a history of legal involvement relating to violent behaviours, including sexual violence, please provide additional information including dates, charges, convictions, and sentencing outcomes.			
Is the participant supervised by a probation officer?	☐ Yes ☐ No	Is the participant currently out on bail?	☐ Yes ☐ No
Bail/Probation Officer's contact name:		Ph:	
Can the participant be supported in program in reference to recent/past charges?			☐ Yes ☐ No
Are there any conditions that we need to be aware of to support the participant's stay?			☐ Yes ☐ No
If yes, please provide details needed to support participant's stay:			
Upcoming court date(s) and location:			
Please provide details (e.g. transportation required, technological requirements, etc.):			
Status under the BC Mental Health Act:	☐ Certified ☐ Voluntary ☐ Extended Leave – Please attach all Forms 4, 6, & 20		

Safe Discharge Plan				
A safe discharge plan 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 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:		
Island Health Community Care Team Contact (Name & Organization/team)				
Ph:		Email:		
Safe Discharge Plan				
Safe discharge location contact name:		Relationship:		
Safe discharge location address:		Location Ph:		
If safe discharge home with family, are they aware?			☐ Yes ☐ No	
If required, alternate safe discharge location and contact information:				
Alternate Safe discharge location contact name:		Relationship:		
Alternate Safe discharge location address:		Location Ph:		
Safe discharge transportation:				
If no, who will transport? (name, phone, relationship)				
Is this safe discharge plan the same for the weekend?	☐ Yes ☐ No	If no, please provide alternative plan below:		

Signatures

By signing below, I consent to the following:

- This referral is being submitted for consideration for an Island Health Regional Substance Use Treatment Bed
- 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)**	
Referral agent agrees to collaborate with the participant to ensure they reconnect with their community services upon discharge.			
Referral agent name (Print):			
Referral agent signature:		**Date: (D/M/Y)**	

Release of Information Form

Consent to Sharing of Personal Information

- 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:	*Referring Clinician agrees to collaborate with the client and service provider as required during and after participation in the contracted treatment program.*
Client Date of Birth:	
Date Signed:	Date Signed:
Client Signature:	Referring Clinician Signature:

AFTERCARE CLINICIAN REFERRAL FORM

Please note: this form only needs to be completed if the referral team is unable to provide ongoing longitudinal care. **Please send the completed referral form to BedBasedACCReferrals@islandhealth.ca for review.**

<table>
<tr><td>Name:</td><td>DOB:</td><td>PHN:</td></tr>
<tr><td>Referral Agent Information
Name:

Agency, Role:

Contact Phone:

Contact Email:</td><td colspan="2">Applicant Phone:

Can we leave a message? Yes ☐ No ☐
Can we communicate via text message?
Yes ☐ No ☐

Applicant Email:

Can we communicate via email? Yes ☐ No ☐</td></tr>
<tr><td>Current Supports: who is helping and supporting the applicant right now?</td><td colspan="2">How can we reach applicant if they are unavailable by phone or email? (family, friend, service provider):

Can we leave a message? Yes ☐ No ☐</td></tr>
</table>

Applicant Goals:

Applicant Consent

I, _____ have consented to a referral to the Aftercare Clinician Program. I further consent to receiving email communications from the ACCs and/or engaging in virtual care through Microsoft Teams, Zoom or telephone.

Date: _____ Signature: _____

OR Verbal consent provided to: _____

Please support client in completing attached ROI form including consent for their referral agent, treatment centre, and any other appropriate persons or organizations.

Program: _____

Authorization to Share Confidential Information: Release of Information

Personal Information							
Name of Person:						*Date of Birth:* *MRN:*	
☐ Consent to share information declined							
I hereby request and authorize _____ to release information to: *(name of facility)*							
Name of person/ agency	*Relationship*	*Information that may be shared:*					
		Appointment schedule	*Medication/ side effects*	*Treatment/ Service Plan*	*Safe Exit/ Discharge Plan*	*Other (please specify)*	*Consent Withdrawn*
							☐ _____ *Signature/Date*
							☐ _____ *Signature/Date*
							☐ _____ *Signature/Date*
							☐ _____ *Signature/Date*
Additional Comments/Specific Details:							

Written Authorization		Verbal authorization *(Requires two witness signatures)*
Signature	*Date*	*Name of Person giving verbal authorization*

Legal Guardian/ Decision Maker signature (if applicable)	*Date*	*Witness signature*	*Date*
* Proof of authority is required			
Health care provider signature	*Date*	*Witness signature*	*Date*
☐ By signing this release form, I give consent for information to be verbally released to the above-named individuals.			
☐ This release form expires:			

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 and non-binary individuals	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)	✗	✗	✗
Offers on-site withdrawal management	✗	✓	✓

Supports pregnant or immediately post-partum participants	Case-by-case	✓	✓
Supports process addictions	✓	✓	✓

Additional Considerations	**Exclusion Criteria**	**Program Discharge Criteria**
The following will also be considered when assessing participants for appropriate treatment match and timing:	*Please contact the site representatives noted on page 2 if unsure about exclusion criteria*	*Requests regarding early transitions/discharge from treatment program may include the following:*
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.