

BCMHSUS Treatment Programs Referral Package

Please indicate which program the client is being referred to:

- Ashnola at the Crossing Treatment Program
- Burnaby Centre for Mental Health & Addiction
- Heartwood Centre for Women
- Provincial Substance Use Treatment Beds

BC Mental Health & Substance Use Services Mandate

BC Mental Health & Substance Use Services, an agency of the Provincial Health Services Authority, provides a diverse range of specialized and one-of-a-kind tertiary mental health and substance use services for individuals across the province.

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 client.

Before submitting this package to a local Health Authority for processing, please ensure the following tasks are complete:

- Complete the included referral form, fill in all applicable boxes
- Complete the program specific forms and attach to referral package
- Include the following collateral information if available and applicable:
 - Current and recent psychiatric and/or medical consult
 - Hospital admission/discharge notes
 - Relevant discharge summaries
 - Forensic assessments (if applicable)
 - Current MAR
- Current Mental Health certificates (if applicable)
- In consultation with the client, complete and attach the Early Exit Transition Plan form
- In consultation with the client, complete and attach Participation Agreement (if applicable). Please ensure it is signed. (If applicable this will be found on the program's web page at www.bcmhsus.ca in the supplementary forms)
- Review program appropriate resident guide with client (this can also be found on the program's web page)
- For Heartwood and Ashnola Programs only** if 19 years of age or older attach current funding for the duration of the 90 day program including coverage for medications while in treatment.
For Burnaby Centre only, include a case note from the current community case manager that indicates
- recent contact with the client, supports the referral to BCMHA, and indicates an active and ongoing partnership with the client

The above components constitute a completed referral and will be reviewed by the program's Admission and Aftercare Committee once received from the Health Authority screening committee.

MSD Funding Verification Instructions: For Heartwood, Burnaby Centre and Ashnola 1. Complete the top part of the form with the referral agent details and the client name

1. For Heartwood, Youth and Young Adult Substance Use Treatment Program only if 19 years of age or older Client must take the form to their ministry office who will complete it and fax back to the referral agent
2. Please send the completed form together with the referral application
3. For all other funding, please follow the instructions on the referral form

Inclusion Criteria	Ashnola	Burnaby Centre	Heartwood	Provincial Substance Use Treatment Program
Problematic substance use	✓	✓	✓	✓
Severe/complex substance use	✓	✓	✓	✓
Severe/complex mental health concerns	X	✓	✓	
BC Resident	✓	✓	✓	✓
Age	17-24	19+	19+	19+
Gender	All	All	Women/Trans-identified Women	All
Medically and Psychiatrically Stable (not requiring acute hospitalization)	✓	✓	✓	✓
Activities of Daily Living: Clients need to have the ability to be independent in their activities of daily living including eating, toileting, and mobilizing.	✓	✓	✓	✓
Mental Health and Addiction Team or a Community Care Team Connection:	✓	✓	✓	✓
Certification/extended leave	X	✓	Extended leave	Extended leave

Additional Considerations	Exclusion Criteria	Program Transition/Discharge Criteria
<i>The following will also be considered when assessing clients for appropriate treatment match and timing</i>	<i>Please contact the Access and Flow Coordinator or Health Authority Liaison for discussion if unsure about exclusion criteria</i>	<i>Requests regarding early transitions/discharge from treatment program may include the following</i>
To ensure safety for all, client mix will be considered (e.g. number of clients with significant medical, behavioural, or severe psychosis/mood and/or disordered eating)	Severe violence including sexual violence	Physical, sexual or verbal threats/abuse/violence Client's presentation or symptoms severity requires care/treatment in acute care/other tertiary facility
A recent history of physical violence	Sexual offences involving minors*	Drug dealing/sharing
Acute suicidality and ideation	Arson/Fire setting	Alcohol or drug use on premises or used on outings with staff
The referring health authority must demonstrate they have exhausted the resources in their Health Authority region.	Unable to support certified or extended leave clients**	Attempted/recruitment of others into gangs or the sex trade
	Unable to support clients with severe/complex mental health concerns**	Recruiting co-clients into illegal or harmful activities
		Persistent drug and alcohol use

***Pertains to Burnaby Centre for Mental Health & Addiction only**

**** Pertains to Ashnola at the Crossing only**

While the inclusion and exclusion criteria are applied, please note that consideration to delaying a client's admission date may occur due to current milieu of program and client-specific needs.

Referral Process

Referrals can be completed by a community support team in collaboration with the client:

- Counsellor
- Social Worker
- Physician
- Psychiatrist
- Community mental and addiction health team provider
- Psychologist
- Nurse Practitioner
- Case Manager

The referring professional/case manager will forward the completed referral package to their health authority liaison. If the health authority screening process approves the client's referral, it is then sent to the access and flow coordinator at the designated BC Mental Health and Substance Use Services site. Once all required information is received, the clinical team reviews the referral within 1-2 weeks depending on program demand and volume of referrals. The treatment match outcome for the referral will be communicated to the health authority liaison by the access and flow coordinator. A formal email communication will be provided to the health authority liaison for clients who are not a match for the referred BC Mental Health and Substance Use Services treatment program. In the instance where another BCMHSUS program is a better match, the liaison will be advised and the referral will be forwarded to the suggested program by the referring access and flow coordinator.

When accepted, the health authority liaison will place the client on a waitlist. If a bed is immediately available, the referring agent or case manager will be advised of the client admission date. The health authority liaison will be advised if the client does not meet the admission criteria.

If there are any further questions please contact the health authority liaison who will be able to assist in completing the form and provide further information.

Please forward the completed referrals to the specific health authority liaison as detailed below:

Ashnola at the Crossing Health Authority Liaison Contacts

Health Authority	Liaison	Email	Phone	Fax
Fraser Health Authority	Marilyn Benning	marilyn.benning@fraserhealth.com	604 613 1811	604 814 5544
Interior Health Authority	Lauren Phillips	lauren.phillips2@interiorhealth.ca	250 314 2700 x 3096	250 314 2410
Island Health Authority	Reg Fleming	reg.fleming@viha.ca	250 519 5313 x 34373	250 519 5314
Northern Health Authority	Destiny Dornbusch	destiny.dornbusch@northernhealth.ca	250 649 7065	250 565 2883
Vancouver Coastal Health Authority	Samantha Brocklebank / Vlad Vasilescu	samantha.brocklebank@vch.ca vlad.vasilescu.vch.ca	604 675 2455 x 22501 604 675 2455 x 22570	604 681 1894
Provincial Health Services Authority	NA	accessandflow@phsa.ca	604 829 8658	

Burnaby Centre for Mental Health & Addiction Health Authority Liaison Contacts

Health Authority	Liaison	Email	Phone	Fax
Fraser Health Authority	John Duong	john.duong@fraserhealth.ca	604 761 4371	604 517 8656
Interior Health Authority	Lauren Phillips	lauren.phillips2@interiorhealth.ca	250 314 2700 x 3096	250 314 2410
Island Health Authority	Dana Leik	Dana.leik@viha.ca	250 709 3337 x 43337	250 737 2695
Northern Health Authority	Doug England	doug.england@northernhealth.ca	250 645 6088	250 649 7219
Vancouver Coastal Health Authority	CAD Team: Kim Barry	N/A	604 875 4111 x 21370 Gen. Inquiries x23066	1 888 857 0371
Provincial Health Services Authority	Andrew Liu / Maricel Diguangco	andrew.liu@phsa.ca maricel.diguangco@phsa.ca	604 675 3950 x69948 604 675 3950 x69948	604 675 3955

Heartwood Centre for Women Health Authority Liaison Contacts

Health Authority	Liaison	Email	Phone	Fax
Fraser Health Authority	Libby Leddy	elizabeth.leddy@fraserhealth.ca	604 614 2383	604 517 8656
Interior Health Authority	Lauren Phillips	lauren.phillips2@interiorhealth.ca	250 314 2700 x 3096	250 314 2410
Island Health Authority	Dana Leik	Dana.leik@viha.ca	250 709 3337 x 43337	250 737 2695
Northern Health Authority	Doug England	doug.england@northernhealth.ca	250 645 6088	250 649 7219
Vancouver Coastal Health Authority	CAD Team: Kim Barry	N/A	604 875 4111 x 21370 Gen. Inquiries: x 23066	1 888 857 0371
Provincial Health Services Authority	Salena Wilson	swilson2@phsa.ca	604 875 3152	

Provincial Substance Use Treatment Program Health Authority Liaison Contacts

Health Authority	Liaison	Email	Phone	Fax
Fraser Health Authority	Sukhvir Brar	sukhvir.brar@fraserhealth.ca	604 614 2383	604 517 8656
Interior Health Authority	Lauren Phillips	lauren.phillips2@interiorhealth.ca	250 314 2700 x 3096	250 314 2410
Island Health Authority	Dana Leik	Dana.leik@viha.ca	250 709 3337 x 43337	250 737 2695
Northern Health Authority	Doug England	doug.england@northernhealth.ca	250 645 6088	250 649 7219
Vancouver Coastal Health Authority	Andrew Stone	andrew.stone@vch.ca	604 675 2455 x 22563	604 681 1894
Provincial Health Services Authority	NA	accessandflow@phsa.ca	604 829 8658	

**Please note that each health authority will have their own criteria for processing referrals to our programs.
Please check with your health authority liaison for more information.**

Client's Referral Information

Referral Date (D/M/Y):	Health Authority:	Is this a FNHA Referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Legal Name:	Preferred Name(s):		
Referring Source:			
If referring source is a hospital, name of hospital and unit:			
Referring Organization:			
Ph:	Fax:	Email:	
MH&A Care Team Name:		MH&A Case Manager Name:	
Email Address:	Ph:	Fax:	
Physician Name:	Ph:	Fax:	
Psychiatrist Name:	Ph:	Fax:	

Client Information

Date of Birth:	Age:	PHN:	
<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Self-identification:	
Current Address:		City:	
Province: BC	Postal Code:	Ph:	Email:

Medical/Pharmacy Coverage/Supports

Type of medical/pharmacy coverage:	3 rd Party Insurer:
Policy #:	ID#:

Cultural Information

Does the client identify as an Indigenous person that is First Nations, Metis or Inuit?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If the client identifies as an Indigenous person are they:			
Status #:	Band:		
Ethnicity (German, Spanish, etc.):	1 st Language:	Is an interpreter needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(Please note that Ashnola is unable to provide interpreters, however, arrangements may be possible)</i>			
We invite the client to let us know if there are any spiritual, religious practices or ceremonies that will support their wellness while in treatment:			

Emergency Contact Person (Family/Friend)

(Please note that the person below will be contacted should there be an emergent concern about safety, medical, etc.)

Name:		Relationship:	
Ph:		Email:	
Is there an identified Substitute Decision Maker (SDM)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name: <input type="text"/>
Ph:		Email:	

Power of Attorney/Trustee

Is there a Power of Attorney in Place?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, provide a brief description: (e.g. finances, treatment decisions, etc.)			
Is there a Trustee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name: <input type="text"/>
Ph:		Email:	

Family Involvement

Does the client have children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# of Children: <input type="text"/>	Minor: <input type="text"/>	Adult: <input type="text"/>
Are the children in foster care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client a custodial parent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of custodial/foster parent(s): <input type="text"/>					
Custodial Parent Ph: <input type="text"/>		Custodial Parent Email: <input type="text"/>			
If child(ren), what is current living situation? <input type="text"/>					
Please provide details, including contact information and MCFD contact information (if appropriate):					
Ph:		Fax:		Email:	
Are there family members that are important to the client 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:					

Current Housing

Please select one:		Stability:		Safety:	
Will the client be able to return to the current living situation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If no, please explain:					

Is there a post-discharge housing plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stability:		Safety:	
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Details:

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Education Level

Please select one:

Client Strengths

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Treatment Goals

This section should be completed in collaboration with the client and their community support team

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How can the client be best supported with their treatment goals while in program?

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Is there any additional information that should be provided at this time?

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Substance Use & Other Process Issues/Concerns

Client has used/has a history with	Select top 3 Drugs of Choice	Current Pattern	Date last used	# Days used in last 30 days	Taken intravenously?	Avg amount used daily	Age at 1 st use
<input type="checkbox"/> Alcohol							
<input type="checkbox"/> Non-beverage Alcohol							
<input type="checkbox"/> Amphetamines							
<input type="checkbox"/> XTC							
<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 (incl. vaping / e-cigs)							
<input type="checkbox"/> Other (Specify):							
<input type="checkbox"/>							
Client has current/history with	Current pattern	Date last active	# Days active last 30 days	Age at 1 st 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							

Substance Use Treatment History

<input type="checkbox"/> Withdrawal Management/Detox/Stabilization	Dates:		Length of stay:	
<input type="checkbox"/> Peer Support Groups (AA/NA/Smart Recovery)	Dates:		How long?	
<input type="checkbox"/> Community Counsellor/Social Worker Support	Dates:		How long?	
<input type="checkbox"/> Residential Treatment Programs (<i>provide details below</i>)				
Program:		Dates:		Length of stay:
Program:		Dates:		Length of stay:
Program:		Dates:		Length of stay:

Other: (please provide details)

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	<i>If yes, please make arrangements when contacted by BCMHSUS</i>		
History of adverse events while in withdrawal? (e.g. seizures)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Last Seizure:		
Delirium Tremors?	<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 client feels would be relevant to support them below:

Medical History

Environmental, Food, Medication Allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
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If yes, provide a brief description and type of reaction(s) and treatment needed:

Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number of weeks:							
Independent of ADLs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:							
Past overdose history?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:							
Does the client have a history of disordered eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the disordered eating still active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
If yes, please define:						Date last active:				
Has the client ever participated in treatment for disordered eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
Medical Dietary Concerns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have any dietary requirements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Please note concerns and requirements here:										
Mobility Issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
If yes, please indicate if any ability aids are being used below:										
Fall Risk:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hep C:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic Disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Head Injury:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Visual Impairment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					FASD/Complex Needs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
						Hearing Impairment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other:										
If yes to any of the above, please provide details below:										
Does the client have any scheduled surgeries, dental appointments or specialist appointments?							<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, provide a brief description:										
DSM V Diagnosis /Mental Health History										
Psychiatric Diagnoses (Axis I):										

Currently on ARV Treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have ARV medications been ordered for treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Currently on antipsychotic IMs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of next required dose:		

Current 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-trade work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Interpersonal/ Domestic violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aggression/anger?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicide attempt(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates of attempts: (please list all dates)					

If there are concerns noted above, please provide detailed information about the safety concern and if possible, provide a copy of the safety plan. ***If yes to any below, please provide the date of most recent along with details for each one***

Legal

Is the client supervised by a probation officer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client currently out on bail?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bail/Probation Officer's contact name:					Ph:	
Are there any conditions that we need to be aware of to support client's stay?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Can client be supported in program in reference to recent/past charges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Please provide details below:						
Upcoming court dates:			Please select one:			
Location:						
Please provide details (e.g. transportation required, technological requirements, etc.):						
Status under the BC Mental Health Act	<input type="checkbox"/> Certified - Please attach Forms 4 & 6	<input type="checkbox"/> Voluntary				
	<input type="checkbox"/> Extended Leave – Please attach Forms 4,6 & 20					

Early Exit Transition Plan

The following plan will be put in place if I leave treatment early. I understand that as I continue treatment, the program will assist me to develop a more complete transition plan to ensure my continued support and recovery when returning home. **It is understood that if I leave the program on short notice or if I do not arrive for my scheduled intake, my referral liaison and my emergency contact will be notified immediately.**

Client Name:					
Key Community Contact for Transition Plan (Name/Relationship):					
Ph:			Email:		
Emergency Contact and/or Next of Kin (Name/Relationship)					
Ph:			Email:		
Community / Health Authority Contact (Name/Agency):					
Ph:			Email:		

