BC MENTAL HEALTH
& SUBSTANCE USE SERVICES
*An Agency of the Provincial Health Services Authority*

Provincial Health Services Authority
Province-wide solutions. Better health.

# 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.

***Revised: May 3, 2019***

# 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 |
|---|---|---|
| *The following will also be considered when assessing clients for appropriate treatment match and timing* | *Please contact the Access and Flow Coordinator or Health Authority Liaison for discussion if unsure about exclusion criteria* | *Requests regarding early transitions/discharge from treatment program may include the following* |
| 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 | Shannon Smith | Shannon.Smith@fraserhealth.ca | 604-520-0911 x522770 | 604-519-8538 |
| 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<br>Vlad Vasilescu | samantha.brocklebank@vch.ca<br>vlad.vasilescu.vch.ca | 604 675 2455 x 22501<br>604 675 2455 x 22570 | 604 681 1894 |
| Provincial Access & Flow Coordinator | | accessandflow@phsa.ca | 604 829 8658 | Please call |

**Burnaby Centre for Mental Health & Addiction Health Authority Liaison Contacts**

| Health Authority | Liaison | Email | Phone | Fax |
|---|---|---|---|---|
| Fraser Health Authority | Sukhi Brar | sukhvir.brar@fraserhealth.ca | 604 613 1811 | 604 519 8538 |
| Interior Health Authority | Lauren Phillips | lauren.phillips2@interiorhealth.ca | 250 314 2700 x 3096 | 250 314 2410 |
| Island Health Authority | Rachael Murphy-Boteler | rachael.murphy-boteler@viha.ca | 250 737 2032 x 44633<br>Cell: 250 710 9600 | 250 737 2695 |
| Northern Health Authority | Doug England | doug.england@northernhealth.ca | 250 645 6088 | 250 649 7219 |
| Vancouver Coastal Health Authority | CAD Team:<br>Serina Lai<br>Kristen LaGrande | N/A | 604 875 4111 x 21370<br>Gen. Inquiries x23066 | 1 888 857 0371 |
| Provincial Access & Flow Coordinator | Andrew Liu / Maricel Diguangco | andrew.liu@phsa.ca<br>maricel.diguangco@phsa.ca | 604 675 3950 x69948<br>604 675 3950 x69948 | 604 675 3955 |

**Heartwood Centre for Women Health Authority Liaison Contacts**

| Health Authority | Liaison | Email | Phone | Fax |
|---|---|---|---|---|
| Fraser Health Authority | Sukhi Brar | sukhvir.brar@fraserhealth.ca | 604 613 1811 | 604 519 8538 |
| Interior Health Authority | Lauren Phillips | lauren.phillips2@interiorhealth.ca | 250 314 2700 x 3096 | 250 314 2410 |
| Island Health Authority | Rachael Murphy-Boteler | rachael.murphy-boteler@viha.ca | 250 737 2032 x 44633<br>Cell: 250 710 9600 | 250 737 2695 |
| Northern Health Authority | Doug England | doug.england@northernhealth.ca | 250 645 6088 | 250 649 7219 |
| Vancouver Coastal Health Authority | Kristen La Grand | Kristen.LaGrande@vch.ca | 604 875 4111 x 21370<br>Gen. Inquiries: x 23066 | 1 888 857 0371 |
| Provincial Access & Flow Coordinator | 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 | Sukhi Brar | sukhvir.brar@fraserhealth.ca | 604 613 1811 | 604 519 8538 |
| Interior Health Authority | Lauren Phillips | lauren.phillips2@interiorhealth.ca | 250 314 2700 x 3096 | 250 314 2410 |
| Island Health Authority | Rachael Murphy-Boteler | rachael.murphy-boteler@viha.ca | 250 737 2032 x 44633<br>Cell: 250 710 9600 | 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 Access & Flow Coordinator | | accessandflow@phsa.ca | 604 829 8658 | Please call |

**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? | ☐ Yes | ☐ 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: | | | |
| ☐ Female | ☐ Male | ☐ Self-identification: | | | | | |
| Current Address: | | | | City: | | | |
| Province: | **BC** | Postal Code: | | Ph: | | Email: | |

## Medical/Pharmacy Coverage/Supports

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

## Cultural Information

| | | | | | | |
|---|---|---|---|---|---|---|
| Does the client identify as an Indigenous person that is First Nations, Metis or Inuit? | ☐ Yes | ☐ No | | | | |
| If the client identifies as an Indigenous person are they: | | | | | | |
| Status #: | | Band: | | | | |
| Ethnicity (German, Spanish, etc.): | | 1st Language: | | Is an interpreter needed? | ☐ Yes | ☐ No |

*(Please note that Ashnola is unable to provide interpreters, however, arrangements may be possible)*

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)? | ☐ Yes ☐ No | Name: | |
| Ph: | | Email: | |

## Power of Attorney/Trustee

| | | | |
|---|---|---|---|
| Is there a Power of Attorney in Place? | ☐ Yes ☐ No | | |
| If yes, provide a brief description: (e.g. finances, treatment decisions, etc.) | | | |
| | | | |
| Is there a Trustee? | ☐ Yes ☐ No | Name: | |
| Ph: | | Email: | |

## Family Involvement

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Does the client have children? | ☐ Yes | ☐ No | # of Children: | | Minor: | | Adult: |
| Are the children in foster care? | ☐ Yes | ☐ No | Is the client a custodial parent? | ☐ Yes | ☐ No | | |
| Name of custodial/foster parent(s): | | | | | | | |
| Custodial Parent Ph: | | Custodial Parent Email: | | | | | |
| If child(ren), what is current living situation? | | | | | | | |
| 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? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No | | | |
| If no, please explain: | | | | | |
| | | | | | |

| Is there a post-discharge housing plan? | ☐ Yes | ☐ No | Stability: | | Safety: | |
|---|---|---|---|---|---|---|
| Details: | | | | | | |

## Education Level

Please select one:

## Client Strengths

## Treatment Goals

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

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

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

## 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 1st use |
|---|---|---|---|---|---|---|---|
| ☐ Alcohol | | | | | | | |
| ☐ Non-beverage Alcohol | | | | | | | |
| ☐ Amphetamines | | | | | | | |
| ☐ XTC | | | | | | | |
| ☐ GHB | | | | | | | |
| ☐ Benzo | | | | | | | |
| ☐ Cannabis | | | | | | | |
| ☐ Cocaine | | | | | | | |
| ☐ Crack Cocaine | | | | | | | |
| ☐ Crystal Meth | | | | | | | |
| ☐ Fentanyl | | | | | | | |
| ☐ Hallucinogens | | | | | | | |
| ☐ Heroin | | | | | | | |
| ☐ Inhalants | | | | | | | |
| ☐ Other Opioids | | | | | | | |
| ☐ Tobacco (incl. vaping / e-cigs) | | | | | | | |
| ☐ Other (Specify): | | | | | | | |

| Client has current/history with | Current pattern | Date last active | # Days active last 30 days | Age at 1st use |
|---|---|---|---|---|
| ☐ Gambling | | | | |
| ☐ Sexual activity | | | | |
| ☐ Pornography | | | | |
| ☐ Shopping | | | | |
| ☐ Shoplifting | | | | |
| ☐ Internet | | | | |
| ☐ Gaming | | | | |
| ☐ Social Media | | | | |

## Substance Use Treatment History

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Withdrawal Management/Detox/Stabilization | Dates: | | Length of stay: | |
| ☐ | Peer Support Groups (AA/NA/Smart Recovery) | Dates: | | How long? | |
| ☐ | Community Counsellor/Social Worker Support | Dates: | | How long? | |
| ☐ | Residential Treatment Programs *(provide details below)* | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 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? | ☐ Yes | ☐ No | *If yes, please make arrangements when contacted by BCMHSUS* | | | |
| History of adverse events while in withdrawal? (e.g. seizures) | ☐ Yes | ☐ No | Date of Last Seizure: | | | |
| Delirium Tremors? | ☐ Yes | ☐ No | Hospital admissions for withdrawal? | ☐ Yes | ☐ No | |

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

## Medical History

| | | |
|---|---|---|
| Environmental, Food, Medication Allergies? | ☐ Yes | ☐ No |

If yes, provide a brief description and type of reaction(s) and treatment needed:

| | | | | |
|---|---|---|---|---|
| Pregnant? | ☐ Yes | ☐ No | Number of weeks: | |
| Independent of ADLs? | ☐ Yes | ☐ No | Details: | |
| Past overdose history? | ☐ Yes | ☐ No | Details: | |

| | | | | | |
|---|---|---|---|---|---|
| Does the client have a history of disordered eating? | ☐ Yes | ☐ No | Is the disordered eating still active? | ☐ Yes | ☐ No |
| If yes, please define: | | | Date last active: | | |
| Has the client ever participated in treatment for disordered eating? | ☐ Yes | ☐ No | | | |
| Medical Dietary Concerns? | ☐ Yes | ☐ No | Does the client have any dietary requirements? | ☐ Yes | ☐ No |

Please note concerns and requirements here:

| | | |
|---|---|---|
| Mobility Issues? | ☐ Yes | ☐ No |

If yes, please indicate if any ability aids are being used below:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Fall Risk: | ☐ Yes | ☐ No | HIV: | ☐ Yes | ☐ No | Hep C: | ☐ Yes | ☐ No | ☐ Unknown |
| Chronic Disease: | ☐ Yes | ☐ No | Prosthesis | ☐ Yes | ☐ No | Head Injury: | ☐ Yes | ☐ No | ☐ Unknown |
| Visual Impairment: | ☐ Yes | ☐ No | | | | FASD/Complex Needs: | ☐ Yes | ☐ No | ☐ Unknown |
| | | | | | | Hearing Impairment: | ☐ Yes | ☐ No | ☐ 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? | ☐ Yes | ☐ No |

If yes, provide a brief description:

## DSM V Diagnosis /Mental Health History

Psychiatric Diagnoses (Axis I):

| |
|---|
| Personality Disorders and Developmental Disabilities (Axis II). Note: For head/brain injury/FASD or cognitive impairment: provide a brief description of cognitive disabilities and attach any collateral assessment/reports (e.g. most recent assessment(s) from psychiatry, O.T, psychology etc.) |
| |
| Medical Illness (Axis III) |
| |
| Psychosocial and Environmental Concerns (Axis IV): |
| |

| | | | |
|---|---|---|---|
| Is the client connected to CLBC? | ☐ Yes | ☐ No | Contact Person: |

| |
|---|
| If yes, provide a brief description: |
| |

| | | | |
|---|---|---|---|
| History of Aggression? | ☐ Yes | ☐ No | *If yes, please attach a brief description of history of verbal and/or physical aggression incidents, outcomes and last occurrence (e.g. throwing objects, yelling, under the influence of substances).* |

| |
|---|
| Effective Intervention(s): |
| |

## Current Medication

***(Please attach a Medication Administration Record or provide information below)***

| Medication and dose | Date Started | Prescriber | Medication and dose | Date Started | Prescriber |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Currently on ARV Treatment? | ☐ Yes | ☐ No | Have ARV medications been ordered for treatment? | ☐ Yes | ☐ No |
| Currently on antipsychotic IMs? | ☐ Yes | ☐ No | Date of next required dose: | | |

## Current Safety Concerns

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Self-harming behaviours? | ☐ Yes | ☐ No | Suicide ideation? | ☐ Yes | ☐ No | Flight Risk? | ☐ Yes | ☐ No |
| Sex-trade work? | ☐ Yes | ☐ No | Interpersonal/ Domestic violence? | ☐ Yes | ☐ No | Aggression/anger? | ☐ Yes | ☐ No |
| Suicide attempt(s)? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No | Is the client currently out on bail? | ☐ Yes | ☐ No |
| Bail/Probation Officer's contact name: | | | Ph: | | |
| Are there any conditions that we need to be aware of to support client's stay? | ☐ Yes | ☐ No | | | |
| Can client be supported in program in reference to recent/past charges? | ☐ Yes | ☐ 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 | ☐ | Certified - Please attach Forms 4 & 6 | ☐ | Voluntary |
| | ☐ | 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: | |

| Weekday Early Exit Discharge Plan | | | | |
|---|---|---|---|---|
| Destination Contact Name/Relationship: | | | | |
| Destination Address: | | | Destination Ph: | |
| Own transport to/from program? | ☐ Yes | ☐ No | Mode of Transportation: | |
| If no, who will transport? (name, phone, relationship): | | | | |
| | | | | |
| *(please provide plane, bus, letter of confirmation for transportation that has been arranged from referral agent or copy of itinerary)* | | | | |

| Weekend Early Exit Discharge Plan | | | | |
|---|---|---|---|---|
| Destination Contact Name/Relationship: | | | | |
| Destination Address: | | | Destination Ph: | |
| Own transport to/from program? | ☐ Yes | ☐ No | Mode of Transportation: | |
| If no, who will transport? (name, phone, relationship): | | | | |
| | | | | |
| *(please provide plane, bus, letter of confirmation for transportation that has been arranged from referral agent or copy of itinerary)* | | | | |

## Signatures

***By signing below, I consent to following:***

- This referral being submitted for consideration for BC Mental Health & Substance Use Treatment Programs
- The information in this referral and any supporting documentation being released and shared between my Community Care Team, Regional health Authority Representatives, BC Mental Health & Substance Use Representatives and BC Mental Health & Substance Use Services Contracted Service Providers
- Should I choose to leave the program early, my Community Care Team, Regional health Authority Representatives, BC Mental Health & Substance Use Representatives and BC Mental Health & Substance Use Services Contracted Service Providers, and Emergency Contact will be contacted and provided with an update
- My Community Physician will be sent a discharge summary

| Client: | Date: | |
|---|---|---|

***Case Manager agrees to collaborate with the client to ensure they reconnect with their community services upon discharge within the Health Authority that this referral was originated.***

| Case Manager Name: | | |
|---|---|---|
| Case Manager Signature: | Date: | |