VANCOUVER COASTAL HEALTH
CENTRAL ADDICTION INTAKE REFERRAL PACKAGE for
SUPPORTIVE TRANSITIONAL LIVING RESIDENCES (STLRs) and TREATMENT FACILITIES

Central City Lodge, New Dawn, Together We Can, Turning Point & Pacifica

REFERRAL INFORMATION

VCH Supportive Transitional Living Residences (STLRs) and Treatment Facilities are live away (tier 4) substance use rehabilitation programs for clients aged 19+ with serious substance use issues and addictions. The programs are located in Vancouver and are generally 90 days in length.

The aim of these programs is to enhance the strengths and skills of substance dependent persons and to empower them, through interventions based on best practice to begin to live lives free of problematic substance use. STLRs and Treatment Facilities offer a substance use-free, structured environment and supportive opportunities to work on substance use related goals. The programs are abstinence-focused and require that clients commit to staying away from substance use while in the program.

REFERRAL CHECKLIST

This package is to be completed by a community counsellor/health care professional in collaboration with the client. Before submitting this package to the Central Addiction Intake team, please ensure the following tasks are complete:

The client and the community counsellor/health care professional have **reviewed**:

- ☐ Referral Information & Instruction section (pages 1-3)
- ☐ Privacy & Consent section (pages 14-15)

The client has **reviewed and signed**:

- ☐ Consent for Release of Information/Authorization (page 15)
- ☐ Participant Agreement (page 16)
- ☐ Funding Verification Form (page 19)
- ☐ PharmaNet Consent Form (page 18)
- ☐ Early Exit Transition Plan (page 17)

If possible, please **attach**:

- ☐ TB Test results
- ☐ Recent (past 2 years) psychiatry reports, medical consultation reports and relevant counsellor notes

CONTENTS

QUESTIONS

The Central Addictions Intake Team
Phone: 604-675-2455 Ext. 22564 for Pacifica, Together We Can & Turning Point
Phone: 604-675-2455 Ext. 22563 for Central City Lodge & New Dawn
Fax: 604-681-1894
Email: CentralAddictionIntakeTeam@vch.ca
Hours of Operation: 8:30am-4:30pm, Monday to Friday
Note: For general inquiries, please email or call either one of the numbers listed above

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PROGRAMS

Vancouver Coastal Health (VCH) works in partnership with and funds services that are provided by five non-profit agencies. Each program offers a unique approach; we encourage referral agents to get to know these resources and to consider a best fit for your client. Additional information about each program can be found on the various program websites listed below:

STLRs

- **New Dawn** (women)…… http://www.chrysalissociety.com/BecomeAClient.aspx
- **Turning Point*** (all genders) …….. http://www.turningpointrecovery.com/
- **Together We Can** (men)…… http://twcvancouver.org/
- **Central City Lodge** (men)…….... http://www.cccares.org/addiction-recovery.html

Treatment Facilities

- **Pacifica Treatment Centre** (all genders)……. http://www.pacificatreatment.ca/

***The relatively small number of beds at Turning Point funded by Vancouver Coastal Health are specifically dedicated to serving trans people and/or women fleeing violence.

The various STLRs and Treatment Centers are gender-separated services. Respectful of gender diversity, we will work with clients to figure out how to provide services that respectfully treat them according to their self-identified gender and sexual orientation. Trans people are welcome at all services

Treatment Facilities offer a more tailored experience (e.g. all day programming) through individual and group work facilitated by counsellors that have advanced training (e.g. a Master's degree) to support people struggling with substance use issues and addictions.

CLIENT CONSIDERATIONS

Please review this section with your client when considering a STLR or Treatment Facility.

These programs may be helpful if you are age 19+ and:

- ☐ substance use is interfering or interrupting your life goals
- ☐ you want help to support your goals
- ☐ you are okay with participating in group work
- ☐ you are okay with living in a small supportive community with other individuals (STLR)
- ☐ you have spoken with a Community Counsellor or Health Care Provider to find out if you may benefit from a live away substance use service.

Call or email the CAIT team to discuss your situation if:

- ☐ if you have a significant brain injury
- ☐ you have a history of setting fires and this poses a current risk
- ☐ you have a history of being sexually and/or physically violent towards others and this poses a current risk
- ☐ you have active TB
- ☐ you need 24/7 physical care and help with basic daily activities (washing, eating, dressing)
- ☐ you have a life threatening medical condition that requires treatment in a hospital or medical restrictions

RESPONSIBILITES FOR REFERRING SERVICE PROVIDER

As a referring service provider you play an important role in helping your client succeed as follows:

- ☐ Supporting client preparation, admission, engagement, retention, and therapeutic alliance
- ☐ Maintain communication with client and their care team
- ☐ Help client maintain connection to community
- ☐ Support transition planning and timely return to community
- ☐ Creating an early exit transition plan (page 17)

If you are not able to stay involved with the client you are referring, please help your client get connected to a resource that can provide this support. If this is not possible, please alert the CAIT team so that they can help make connections to resources for the client.

TRANSITION PLANNING

Transition planning starts as early as possible during the client's stay at the STLR or Treatment Facility. The client and the STLR or Treatment Centre staff will work with clients, families and service providers in the client's home community (e.g. Community Counsellor or Health Care Professional) as early as possible to develop a transition plan. Once the client has completed services at the STLR or Treatment Centre, the client will be transferred back to the referring home community service provider for ongoing services and supports.

If a client has been made aware of an issue that may result in early discharge from the program, the STLR or Treatment Facility staff will strive to inform home community service providers to facilitate a safe transition for the client back to community.

An Early Exit Transition Plan is vital to maintaining a client's safety, especially in situations where a client is discharged from the program early with little notice or if the client decides to leave the STLR or Treatment Facility before completing the program**. An Early Exit Transition Plan is included in this referral package** (see page 17).

CENTRAL ADDICTION INTAKE TEAM (CAIT)

The Central Addiction Intake team can provide additional information about the programs and assist with some of the client's preparation needs, if required. Please call CAIT if you have any questions about the programs or process.

Waitlist Check-In Requirement:

Once the referral package is submitted, clients should maintain weekly check in calls with the CAIT team to maintain their waitlist status, as changes can occur quickly.

- Clients waitlisted for **Pacifica, or Together We Can** should call: **604-675-2455 Ext. 22564**
- Clients waitlisted for **Central City Lodge** should call: **604-675-2455 Ext 22563**
- Clients waitlisted for **Turning Point Vancouver** should call **604-875-1710**
- Clients waitlisted for **New Dawn** should call: **604-325-0576**

If accessing a phone with voicemail is a challenge, CAIT can offer alternate options to connect (e.g. via email, referral agents' office, a primary care clinic, a community drop-in, etc.).

QUESTIONS or GENERAL INQUIRIES

The Central Addictions Intake Team
Phone: 604-675-2455
Fax: 604-681-1894
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GENERAL INFORMATION

Date of Referral: ____(DD)/____(MM)/____(YYYY)	**Date of Birth:** ____(DD)/____(MM)/____(YYYY) **Age:**_____

Client's Community Health Authority:

o Vancouver Coastal Health oInterior Health oFraser Health oNorthern Health oIsland Health

Program You are Referring To:

STLRs:
o Central City Lodge (men) o Together We Can (men) o New Dawn (women) o Turning Point* (all genders)

Treatment Facilities:
o Pacifica (all genders) Note: Trans people are welcome at *all resources.*

*The beds funded by Vancouver Coastal Health at Turning Point are dedicated to serving marginalized individuals, including trans people and women fleeing violence.

Who is making the referral?

Name:_____

Agency Name: _____

Role:_____

Phone #:_____Email:_____ Fax #: _____

How many sessions have you had with the client? ____

Will you continue to support your client through and after their stay at the STLR or Treatment Facility? Yes O No O

CLIENT INFORMATION

Legal Name:		
Preferred Name(s):		
Social Insurance Number:		Personal Health Number (PHN):
Street Address:		
City:	Province:	Postal Code:
Telephone:	Okay to leave a message? Yes No	Email:

CLIENT INFORMATION - CONTINUED

Client name: Referral Date:

Emergency Contact Information:

Name: Relationship: Phone:

Can we contact this person if you are discharged early from the STLR or Treatment Facility? Yes O No O

If not, is there another individual we can contact in this situation?

Do you have any children under 19? Yes O No O Are they living with you? Yes O No O

Is MCFD involved? Yes O No O Please provide additional info, if necessary:

CULTURAL INFORMATION

We invite you to let us know if there are any traditional practices or ceremonies that will support your wellness while at the STLR or Treatment Facility:

Is there anything you would like us to know that we have not included here about you or your culture?

Do you identify yourself as an Aboriginal person, that is First Nations, Metis or Inuit? Yes O No O

If you identify as an Aboriginal person, are you: First Nations O Metis O Inuit O

Status: Yes O No O Band:

CLIENT'S STRENGHTS, INTERESTS, HOPES

Tell us about your strengths and positive qualities:

Tell us about your interests, talents and passions:

Tell us about your hopes for treatment:

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SUBSTANCE USE TREATMENT HISTORY

Client name: Referral Date:

Have you completed a withdrawal management program (including home detox, daytox)? Yes No

If yes, please list most recent dates, where, and for what substances:

Have you ever participated in substance use services and supports (including counsellor, outpatient clinic, AA, NA, etc)? Yes No

If yes, please list most recent dates, where, and what substances you were using at the time:

What has been helpful in your past recovery or support experiences?

What has been unhelpful in your past treatment or support experiences?

GENDER AND SEXUAL ORIENTATION

The various STLRs and Treatment Facilities are gender-separated services. Respectful of gender diversity, we will work with clients to figure out how to provide services in this setting that respectfully treat them according to their self-identified gender and sexual orientation. Gender is diverse and we invite you to let us know what gender you identify with:

Male Female Gender Creative/Fluid Transgender: MTF FTM Other:_____Prefer not to answer

What pronoun would you like us to use? He She They Other: _____

Sexual orientation is diverse and we invite you to let us know your sexual orientation:

Heterosexual Lesbian Gay Bisexual Queer Questioning
Two-Spirit Pansexual Asexual Other:_____Prefer not to answer

Is your reason for getting help (substance use, mental health concerns) related to any issues around your sexual orientation or gender identity?
Not at all A little Somewhat A lot Unsure Prefer not to answer

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SUBSTANCE USE (If VCH referral, see CAV3)							
Client name:				Referral Date:			
Primary Problem (Yes/No)	**Substance**	**Primary Route of use** (Oral, nasal, Sublingual, smoke inhale, anal, intravenous, intra muscular, transbuccal)	**# of days used in last 30 days**	**Amount Used in a Typical Day**	**Age at First Use**	**Current Use**	**Stage of Change**
	Alcohol						
	Non-Beverage Alcohol						
	Tobacco						
	Cannabis						
	Crack Cocaine						
	Cocaine						
	Heroin						
	Opiates						
	Opiates						
	Benzos						
	Crystal Meth						
	Amphetamines						
	Club Drugs						
	Hallucinogens						
	Inhalants						
	Over the Counter						
	Other Rx Meds						
	Other						

Client name:	Referral Date:

Have you ever accidentally overdosed? *Yes* *No*

If yes, please tell us briefly about the most recent date this happened:

OTHER PROBLEMATIC BEHAVIOURS

Do you or anyone in your life have concerns that you might have problems with any of the following behaviours (that is, you spend a lot of time, spend more money than you intended and/or it's interfering with other responsibilities)?

	Yes	No	Hours per day/Days per month
Shopping			
Sexual activity			
Gambling			
Pornography			
Other (Internet Overuse, Shoplifting, Theft, or _____)			

CLIENT'S HEALTH

Last TB Test (Date):
Attach results with this form (Chest x-ray, Mantoux skin test)

Are you pregnant? Yes O No O Unsure O N/A O	Number of weeks pregnant:
Do you have a history of seizures? Yes O No O	Date of last seizure:

If yes, please let us know the cause of the seizures, if known (substance use related?):

Do you have any of the following, ongoing, health conditions?

Asthma O breathing problems O heart problems O circulatory issues O stomach problems O

Do you take medication for these conditions? If so, what?

Do you have diabetes? Yes O No O If yes, is it managed with meds? Yes O No O

Do you have any allergies? Yes O No O What is required to manage your allergies?

Do you require an epi-pen for allergies? Yes O No O

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Client name:	Referral Date:

Do you have any special dietary needs? Yes O No O If yes, please describe:

Do you have any mobility issues? Yes O No O

Do you use a walker? Yes O No O Or a wheelchair? Yes O No O

If yes, please tell us briefly about your mobility concerns/needs:

MENTAL HEALTH

Do you have any mental health concerns? Yes O No O

What are your concerns?

Have you received a mental health diagnosis? Yes O No O If yes, please elaborate:

Are you on medications for mental health concerns? Yes O No O

What medication are you on?

Is this medication helpful? Yes O No O Please comment:

When was the last time you had significant problems with…

1. Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?
   Past month O 2-3 mo's ago O 4-12 mo's ago O 1+year ago O Never O
2. Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?
   Past month O 2-3 mo's ago O 4-12 mo's ago O 1+year ago O Never O
3. Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?
   Past month O 2-3 mo's ago O 4-12 mo's ago O 1+year ago O Never O
4. Becoming very distressed and upset when something reminded you of the past?
   Past month O 2-3 mo's ago O 4-12 mo's ago O 1+year ago O Never O
5. Seeing or hearing things that no one else could see or hear, or feeling that someone else could read or control your thoughts?
   Past month O 2-3 mo's ago O 4-12 mo's ago O 1+year ago O Never O

Client name:	Referral Date:

MENTAL HEALTH – CONTINUED

Do you have any history of disordered eating? Yes O No O If yes, please elaborate:

Binging Purging Restricting Laxatives Excessive exercising Other, please describe:

Have you ever participated in treatment for disordered eating? Yes No

If yes, please tell us briefly about this:

Is the disordered eating still active? Yes O No O	If no, when was it last active?

Do you engage in self-harming behaviours (cutting, burning, scratching)? Yes O No O
If yes, is self-harm currently active? Yes O No O Please comment:

Do you have thoughts of killing yourself (committing suicide)? Yes O No O Not Assessed

If yes, do you have a current plan for suicide? Yes O No O If yes, please elaborate:

Have you ever attempted suicide? Yes O No O
If yes, date of most recent attempt:

Have you experienced a head injury or head trauma Yes O No O If yes, please tell us briefly about current head injury related concerns:

Do you often feel confused or overwhelmed in new places? Yes O No O If yes, please tell us more information about this:

Client name: Referral Date:

CURRENT MEDICATIONS

Note: We will search Pharmanet for a list of your current medications. A consent form is attached (see page 18).

Do you have any concerns about your current medications?

Are you on current opiate maintenance therapy? Yes O No O Which therapy?

Who is your care provider?

Start Date: Current Dose:

Current Opiate Maintenance Therapy Details:

PSYCHOLOGICAL & SOCIAL

Have you ever experienced problems controlling your anger / aggression? Yes O No O If yes, please tell us briefly about any anger or aggression concerns that are current or in the recent past:

Are you currently experiencing violence? Yes O No O Have you experienced violence in the past? Yes O No O If yes, please tell us briefly about any concerns related to your current safety:

Do you have concerns for your safety related to your care in the program? Yes O No O. Please elaborate:

Do you have safety concerns related to aftercare? Yes O No O. Please elaborate:

Do you have any concerns about being in a group setting/environment? Yes O No O. Please elaborate:

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Client name:	Referral Date:

HOUSING

What is your current housing situation?

Is your current housing situation: Safe O Unsafe O ?

Details:

Do you need help with a housing plan? Yes O No O.

LEGAL CIRCUMSTANCES

Do you have any upcoming court dates? Yes O No O.

If yes, when and where (please attach more information if needed):

Are you on probation or parole? Yes O No O.

Do you have a conditional sentence? Yes O No O. Charges? Yes O No O.

If yes to any of the above, please provide contact information on consent form.

FINANCIAL CIRCUMSTANCES

What is your funding source for the STLR or Treatment Facility stay?

Income Assistance PWD Accommodation Fee Subsidy Other_____

Have you applied for Income Assistance? Yes O No O I don't know O
If yes, application #_____

Do you have an open file with MSDSI? Yes O No O I don't know O

PRIVACY AND CONSENT

Privacy at Vancouver Coastal Health Authority

- When you are receiving care from any of the programs or services at Vancouver Coastal Health Authority (VCH), personal information needs to be collected from you by counsellors, health care practitioners and other healthcare team members.
- We collect, use and share this information when required or permitted by law; for example, according to British Columbia's *Hospital Act*, *Hospital Insurance Act*, and the *Freedom of Information and Protection of Privacy Act* (FIPPA).
- Sometimes your family, friends, or someone who has the legal right to represent you, may also give us personal information about you.
- We may also need to get personal information from other sources, such as copies of your previous health records from other hospitals or from your family physician, or we may confirm your identity and personal health number (PHN) with the Ministry of Health.

Vancouver Coastal Health is ethically committed and legally required, to protect your personal information.

We are committed and legally required by *Freedom of Information and Protection of Privacy Act* (FIPPA) to protect your privacy. We use and share your information for authorized purposes and must store it securely to protect it. Our staff are trained on how to protect your privacy and to keep your personal information confidential at all times.

Who can look at, use, and share my personal information?

Someone who "**needs to know**" your information in order to provide care and other care-related services, is permitted to look at your personal information (like a counsellor or a nurse). They may use and share it for the following reasons:

- To assist with your ongoing care and services
- To contact you or your family about your medical care when appropriate
- To help us improve the quality of your care and services
- Research (when authorized)
- Teaching and education (of counsellors and nurses, for example)
- To see if you qualify for different benefits or services and to arrange payment.

Your personal information may also be shared with other people with your consent. However, we must provide it without your consent in some circumstances. These include:

- To respond to a court order or subpoena
- To comply with an insurance investigation by another government body such as WorkSafe BC
- To report or provide information to investigate a suspicion that a child or an older adult is being abused or neglected
- To report intention of self-harm or harm to another person

If you have any questions or concerns about the limits of confidentiality, you are encouraged to speak with your counsellor, health care provider, or the VCH Privacy Office (604-875-5568 or privacy@vch.ca). Our program is committed to being as open as possible about our responsibilities to both you and the community.

CONSENT FOR RELEASE OF INFORMATION

Please indicate below your consent for STLR or Treatment Facility and CAIT staff to share your personal information with the following individuals:

SERVICE PROVIDER	NAME	TELEPHONE # (Include extensions)	Specify any limitations to the information you consent to share
Probation or Parole Officer			
Lawyer			
Other (consider family who may be involved in your arrival plans)			
Other			

CLIENT AUTHORIZATION

I,_____(full name) have reviewed the information in the Privacy and Consent section (on page 14). I consent to the release of information as specified above (if applicable).

PRINTED NAME_____ SIGNATURE_____

DATE: _____(DD)/_____(MM)/_____(YYYY)

WITNESS:

PRINTED NAME_____ SIGNATURE _____

RELATIONSHIP _____ DATE: _____ (DD)/_____(MM)/ _____ (YYYY)

VCH collects, uses, and shares personal information only in accordance with the *BC Freedom of Information and Protection of Privacy Act*

PARTICIPANT AGREEMENT

I, _____, (full name) have reviewed the referral information and *Client Considerations* section. I agree to voluntarily apply for services with the STLR or Treatment Facility selected.

I agree while I am in the program I will:

- O treat others with respect and dignity and without discrimination
- O honour the privacy and right to confidentiality of others

I agree to participate in the following activities upon arrival at the STLR:

- O medical assessment with the program doctors and nurses
- O medication review including handing in all medications to the program staff
- O urine sample and breathalyzer, if requested
- O review of your personal belongings in your presence
- O program orientation with staff

SIGNATURE_____

PRINTED NAME_____ DATE:_____ (DD)/_____(MM)/_____ (YYYY)

COMMUNITY COUNSELLOR/HEALTH CARE PROFESSIONAL:

SIGNATURE_____

PRINTED NAME _____ DATE: _____(DD)/_____(MM/_____YYYY)

QUESTIONS

The Central Addictions Intake Team
Phone: 604-675-2455 Ext. 22565 for Pacifica, Together We Can & Turning Point
Phone: 604-675-2455 Ext. 22563 for Central City Lodge & New Dawn
Fax: 604-681-1894
Email: CentralAddictionIntakeTeam@vch.ca
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Note: For general inquiries, please email or call either one of the numbers listed above

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EARLY EXIT TRANSITION PLAN

Should I leave the selected STLR or Treatment Centre prior to program completion, **I agree to utilize the support of the STLR or Treatment Facility staff for resource information, and safe exit/transition planning and**:

O Return to my home and/or the home of the individual named below for immediate shelter and transition support;

and/or

O Contact the agency/worker named below for immediate shelter and transition support.

EARLY EXIT CONTACTS:

1) Name_____Relationship _____
   Home #: _____ Cell #: _____

2) Name_____Relationship _____
   Home #: _____ Cell #: _____

3) Organization/Agency Name: _____ Contact/Workers Name _____
   Phone #: _____ Cell #:_____

SIGNATURE_____

PRINTED NAME_____ DATE:_____ (DD)/_____(MM)/_____(YYYY)

COMMUNITY COUNSELLOR/HEALTH CARE PROFESSIONAL:

SIGNATURE_____

PRINTED NAME _____ DATE: _____ (DD)/_____(MM)/_____YYYY)

ADDITIONAL INFORMATION (e.g. details of your Early Exit Transition Plan):

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BRITISH COLUMBIA
Ministry of Health

Patient Consent for Treatment Providers to Access PharmaNet Information

The Province of British Columbia has established the provincial computerized pharmacy network and database known as "PharmaNet" pursuant to Section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363.

REGARDING: ..... [Patient Name, Please Print]

DOB: .....**PHN#:** .....

I, ..., [Patient Name, Please Print], authorize access to my personal health information contained within Pharmanet by medical practitioners, pharmacists, and other authorized persons for the purpose of providing therapeutic treatment or care to me in ..... [Facility Name, Please Print] ("the Facility").

If I have a keyword on my medication profile, I will provide the keyword to enable the Facility's access to my PharmaNet information as required. When I am no longer receiving care or treatment from the Facility, the keyword that I have provided will be removed from all records relating to me.

I understand that if I am not able, for any reason, to provide my keyword, and a medical practitioner has reasonable grounds to believe that safe and effective care and treatment cannot be provided without accessing my medication profile, he/she will do so by contacting the PharmaNet Help Desk to have the keyword removed from my profile.

I understand that this consent will expire when I am no longer receiving care or treatment from the Facility. If I wish to withdraw this consent prior to that time, I understand that the withdrawal must be in writing and delivered to the Facility directly.

Signed at ....., British Columbia, this ..... day of ..... , 20.....

....

Patient/Guardian Signature Witness Signature

.....

Witness Name, Please Print

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SDSI FUNDING VERIFICATION

Must be processed by SDSI & sent back within the same day

Date _____

Referring Agent : Please complete and return to CAIT, Fax No. 604-681-1894

Ministry Agent: Please complete and return to CAIT, Fax No. 604-681-1894

CLIENT NAME _____ D.O.B. ____ / ____ / _____
DD MM YYYY

S.I.N. _____

This person has been referred for admission to _____ residential addictions program. Prior to admission, we require confirmation that the client's per diem costs (less any non exempt income) will be paid by SDSI while in receipt of, and eligible for, income assistance. Once the client has been admitted the facility will send an admission report.

Income from Other Sources $ _____ Source _____

Client Authorization I, ……., authorize the Ministry of Social Development & Social Innovation to confirm my eligibility for funding, and to release any related information to the staff of Vancouver Coastal Health CAIT program and the above named residential/support recovery addictions program.

…….. Date……..

Client Signature

Ministry of Social Development & Social Innovation - *COMPLETE & SEND BACK THE SAME DAY*

☐ **Client has an open and active file**
☐ **Client eligibility yet to be determined**
☐ **Client file has been closed**
☐ **Client is eligible for funding as follows:**

Comments

Client's monthly per diem will be paid by SDSI as per current eligibility less any non exempt income from other sources as follows:

Client Contribution (non exempt income) $ _____

Non exempt income from _____

Maximum Amount Payable by SDSI Per Month $ _____

SDSI Contact Name _____

Tel _____

Date

Place Office Stamp Here

Note: the following pages are specific to Pacifica Treatment Center referrals

STANDING ORDER MEDICATIONS

Client Name _____ Date _____

Medication Allergies: _____

Physician must indicate whether or not the following medications can be administered to the above client by initialing the appropriate box for each medication.

			Physician Initials	
Indication	**Medication & Dosage**	**Instructions**	**Yes**	**No**
PAIN Headache, Mild Muscle or Joint Pain Fever (eg. Cold)	**Ibuprofen (Advil)** 200mg - 1-2 tablets every 4-6 hrs PRN with food **Acetaminophen (Tylenol) extra strength** 500mg – 1-2 tablets every 4 -6 hrs PRN Max: 3000mg/24 hrs	• Give for 48 hrs only for any complaint • If persistent, contact physician		
COUGH	**Nin Jiom** 5–10 ml (1-2 tsp) every 4 – 6 hrs PRN	• Give for 48 hrs • If persistent, contact physician		
NAUSEA / VOMITING Lasting more than 6 hrs	Ginger Gravol – 2 tablets three times daily as needed. Dimenhydrinate - 50mg 3 times daily as needed *contact Dr before administering	• Give for 48 hrs • If persistent, contact physician		
INDIGESTION Complaints of burning epi-gastric pain	**Calcium Carbonate (Tums)** 1 or 2 Max 8/day	• Give for 48 hrs • If persistent, contact physician		
CONSTIPATION	Lactulose 20-40 ml daily	• Contact physician if condition worsens or persists		
DIARRHEA	Loperamide 2mg – 2 tablets 3 times daily as needed *contact doctor before administering			
NALOXONE	o.4 – o.9 mg. q 5-10 minutes Intramuscular injection PRN x 3 doses as per facility policy	• intramuscular injection as required in the event of an opiate overdose	√	

Physician Name _____ **CPSID #** _____

Physician Signature _____ **Date** _____

This Standing Medication Order is in effect for one year from date signed

Pharmacy at SAFEWAY

Dear Sir or Madam:

We are pleased to inform you that Safeway Pharmacy at Broadway and Commercial in Vancouver will be providing prescription and specialized pharmacy services to you or your family member at Pacifica Treatment Center.

One of our Safeway Pharmacists, Ann Kubota, will be the primary pharmacist involved with the health care team, and will also be available to you to answer your medication and health related questions at Pacifica Treatment Center. Our Pharmacy phone number is (604) 879-0505.

If a medication is not covered by PharmaCare, one of our pharmacy team members can be available to call the responsible family member to discuss the medication and associated costs. Payment of all prescription, non-prescription, over-the-counter (e.g. vitamins) medications or supplies provided by Safeway Pharmacy is the responsibility of the resident.

- ***Secondary Medication Insurance Plans***: If you have an insurance plan other than the Primary Provincial coverage that Safeway Pharmacy can direct bill, e.g. Veterans Affairs (DVA), DIA or Status Card, Assure Health, etc, please contact Safeway Pharmacy at Broadway and Commercial.
- ***Requests for Receipts:*** Should you require prescription receipts for non-benefit medications, please contact Safeway Pharmacy at Broadway and Commercial. Upon request, receipts can be mailed out to the Financial Power of Attorney and/or the resident once monthly or when required.
- **Medical Expense Summaries** for Income Tax purposes will be provided upon request. This is only supplied when the account is paid in full.

Safeway Pharmacy will provide weekly invoices for any amount not covered by PharmaCare or any extended medical coverage is able to offer 2 payment options:

- ❑ Pre-Authorized Credit Card (via VISA, MasterCard and American Express) ☐Please see attached form
- ❑ Cash or debit in person at the Broadway and Commercial Safeway Pharmacy

If you are unable to pay for any prescription, non-prescription, over-the-counter (e.g. vitamins) medications or supplies that may be prescribed to you, please notify Pacifica staff and/or Safeway Pharmacy.

If you have any questions or concerns about medications, please call Safeway Pharmacy at (604) 879-0505. On behalf of the Pharmacy Team at Safeway, we look forward to serving you.

Sincerely,
Your Pharmacy Team at Safeway Pharmacy and Safeway Operations, Sobeys Inc.

Ann Kubota, B.Sc.Pharm. R.Ph.
Pharmacy Manager
Safeway Pharmacy (Broadway and Commercial)

Farzin Rawji, BScPharm, Manager, Business Development, Continuing Care Pharmacy Services (West), National Pharmacy Group, Sobeys | Lawtons Drugs | Safeway

I have read and understand that I am responsible to pay Safeway Pharmacy for any pharmacy items provided that are not covered by PharmaCare or any extended medical coverage.

Name:_____ Date:_____ Signature: _____

Pharmacy at SAFEWAY

Facility: Pacifica Treatment Centre

Date: _____

RESIDENT STATUS FORM

A. RESIDENT INFORMATION

Name: _____

Admission/Move-in Date: _____ Birth Date: _____ Physician: _____ Telephone: _____ Allergies: _____ Diagnosis/medical conditions: _____

_____

B. PHARMACARE AND INSURANCE/COVERAGE, BILLING INFORMATION:

Pharmacare (PHN) Care Card #: _____ NIHB #: _____ Veteran Affairs Info: K # _____ Other Third Party Insurance/Coverage Information (e.g. Pacific Blue Cross, Green Shield, etc.):

_____

_____

PACIFICA
treatment centre

1755 East 11th Avenue Vancouver, B.C. V5N 1Y9
Telephone: 604 872-5517 Fax: 604 872-3554 Toll Free: 1 866 446 0668

Promoting health & recovery from addiction.

Dear Doctor:

Your patient is currently being assessed for admission to Pacifica Treatment Centre for the treatment of chemical dependency. **Please complete and return to us the accompanying medical form as this documentation is required before we can we can consider your patient for admission.** Please note that as Pacifica is not a medical facility, clients must be detoxed prior to admission and be medically stable both mentally and physically. Frequently clients need to attend residential detox or complete a tapered withdrawal under medical supervision. Clients with less than 72 hours will not be admitted. Pacifica reserves the right to not admit a client if the client appears medically unstable and/or exhibits signs of acute withdrawal. Private clients are urine screened upon arrival.

The first 2-4 weeks are specifically designed to assist those clients who have completed the detox process but need a longer period of stabilization during the Post-Acute Withdrawal Phase. Beyond this initial period the program is designed on an intensive group therapy model and requires that clients be physically, emotionally and mentally able to fully participate. Private pay who have the option of a shorter duration of treatment require a minimum of two weeks abstinence, or will need to extend their stay to build in that sobriety before engaging in the intensive treatment phase.

In accordance with our Community Care Licensing requirements all medications must be ordered from **Safeway Pharmacy** which is our designated pharmacy. Medications will be dispensed by Safeway Pharmacy in the approved Pacmed packaging on a weekly basis and administered by Pacifica staff as prescribed. Safeway Pharmacy must dispense all prescription medications, non-prescription medications and any supplements. Pacifica will only administer antidepressant and antipsychotic medications on a fixed dose schedule, not on a PRN basis. Clients are responsible for the weekly cost of these medications and supplements and for their associated dispensing fees. Clients requiring medication should receive an adequate prescription to sustain them through treatment.

Regarding Methadone and Suboxone, please provide a minimum 4 week prescription. For long term stable dose patients a 12 week script would be appreciated. However, the Pacifica physician can prescribe Methadone and Suboxone. Dosage adjustments may be made during the treatment period if appropriate, but this is determined on the basis of clinical assessment. We do not taper patients off maintenance therapy while they are in Pacifica. Bridging prescriptions are provided if appropriate upon discharge. Methadone and Suboxone are dispensed by daily witnessed ingestion at Safeway pharmacy.

Pacifica provides basic OTC medications for minor ailments subject to pre-approval on the standing order form – see enclosed form. Please review and document your approval on that form. Any other OTC meds or supplements will need to be prescribed by the on-site physician. We generally do not allow multiple vitamin supplements, herbal medications, or protein/caloric powders or drinks. In order to avoid the problems caused by multi-doctoring, Pacifica will review Patient Pharmanet prior to admission.

The following medications are not permitted in Pacifica: opioids other than Methadone or Suboxone; Simulants; Sedative hypnotics (benzodiazepines and Z-drugs), and sedating antihistamines.

Yours truly,
Dr. Mark Viljoen, MBBCh
Medical Consultant

Safeway Pharmacy, 1780 E. Broadway Vancouver, B.C. V5N 5Y3
Telephone # 604-879-0505 Fax # 604-873-6144

Enclosure (Physician Report 2 pages)

PACIFICA
treatment centre

1755 East 11th Avenue Vancouver, B.C. V5N 1Y9
Telephone: 604 872-5517 Fax: 604 872-3554 Toll Free: 1 866 446 0668

Promoting health & recovery from addiction.

ATTENTION: Physician/Referral Agent
Methadone/Suboxone maintained clients at Pacifica

Methadone/Suboxone maintained clients are eligible for admission to the Pacifica residential treatment program if they meet all other admission criteria. Refer to Pacifica admission criteria.

The "physician report" must be completed by the Methadone/Suboxone prescribing physician and should include all relevant medical, psychiatric and addiction history.

Methadone/Suboxone maintained clients must be on a stable maintenance dose prior to admission to Pacifica Treatment Centre. This implies that they are at an appropriate dose to suppress opioid withdrawal and minimize/prevent craving. It also implies that they have become tolerant to the sedative effects from the Methadone/Suboxone and able to fully participate in the program.

Adjustments to the Methadone/Suboxone dose will only be made on the basis of clinical need, and not on a client's desire to taper off maintenance therapy. Once the initial script has been completed subsequent scripts for Methadone/Suboxone will be managed by the on-site physician for the duration of the patient's stay.

Methadone/Suboxone maintained clients will not be admitted until the arrangements have been made for the dispensing at Safeway Pharmacy. At discharge, the designated Pacifica pharmacist will cancel the current prescription and the patient will be required to transition back to their previous provider or to make arrangements with a new prescribing doctor.

If Methadone/Suboxone maintained clients are discharged early for non-compliance or if they choose to withdraw from the program it will be considered the patient's responsibility to contact his/her physician for a new prescription. With approval of the Pacifica's physician the prematurely discharged patient may be eligible for continued dispensing at Pacifica's pharmacy for a few days to allow time to consult with their Methadone/Suboxone prescribing physician.

In general terms Methadone/Suboxone will be treated like any other medication which is medically indicated and Methadone/Suboxone maintained clients will be fully integrated into the program. The focus of treatment is on the acquiring of non-chemical coping skills and the development of relapse skills and will not focus on the merits of Methadone/Suboxone maintenance. All prospective Methadone / Suboxone maintained clients will be asked to review the conditions outlined above and to confirm that they agree with these conditions of their admission.

PACIFICA
treatment centre

Treatment contract for clients on Methadone/Suboxone Maintenance due for admission to Pacifica

Name of client _____ **PHN#:** _____

I understand that I will be eligible for admission only if I meet all admission criteria

I understand that the **"physician report"** must be completed by my Methadone/Suboxone prescriber who will be made aware of the conditions for admission to Pacifica Treatment Centre and may be contacted by the Pacifica designated pharmacist.

I understand that I must be on a sufficiently stable dose to ensure that I am not experiencing opioid withdrawal symptoms or unmanageable cravings. I also understand that this means that I am not excessively sedated so as to preclude active participation in the program.

Methadone/Suboxone will be treated like any other medication and Methadone/Suboxone maintained clients will be fully integrated into the program. The focus of treatment is on the acquiring of non-chemical coping skills and the development of relapse skills and will not focus on the merits of Methadone/Suboxone maintenance.

I understand that I will be maintained on my dose of Methadone/Suboxone for the duration of my stay at Pacifica and Methadone/Suboxone will **NOT** be allowed to taper during this time. Any adjustments to my dose level during treatment will be the result of the physician's clinical assessment and not my preference to taper.

In most cases Methadone/Suboxone will continue to be prescribed by my regular Methadone/Suboxone prescriber while I am at Pacifica and dispensing will be switched from my regular pharmacy to the designated Pacifica pharmacy for the duration of my stay at Pacifica. Methadone/Suboxone will be administered daily under supervision by the local pharmacist or a Pacifica staff member. I understand that I am expected to bring in a Methadone/Suboxone prescription that will **start the day after** my admission and to last for a minimum one month period. Alternatively, my physician may make arrangements for the required script to be sent directly to the Safeway pharmacy.

I understand that "split dosing" is not allowed at Pacifica unless there is a clinically verified need for this. Lacking such evidence, I will be maintained on a once daily witnessed ingestion regime.

If I am discharged prematurely for non-compliance or if I choose to leave before the program is completed Pacifica staff will no longer be responsible for my Methadone/Suboxone. It will then be my responsibility to contact my Methadone/Suboxone prescriber to arrange a new prescription. If authorized by the Pacifica physician it may be possible to continue receiving Methadone/Suboxone for a few days after discharge to allow for the transition to a new provider/pharmacy. At the end of the normal treatment process I understand that I will be able get a bridging prescription to facilitate my smooth transition to my previous or a new provider.

I have read and agree with the above terms and conditions.

Signed:_____Witness:_____ Date: _____

Client (Client)

Referral (Referral)