THE DIANE HARWOOD CENTRE FOR WOMEN

Part 1: Instructions

How to Apply

1. Complete this Preliminary Intake Assessment Form.
2. Send your referral form to VancouverHL.DHCWintake@salvationarmy.ca or by fax to 604-682-1673.
3. Phone our Intake Counsellor at **604-646-6842** between 9am-4pm Tuesday-Saturday to confirm that we received your form and learn more about our intake process.

The Intake Counsellor may ask some follow-up questions to better understand your individual needs and what you are looking for in a treatment program. Incomplete forms will delay your application for Harbour Light's program. *Please note:* all applicants must be 19 years or older.

Waitlist

Our program may have a waitlist for new intakes. If you are on the waitlist, it is your responsibility to leave a phone message with the Intake Counsellor once a week to maintain your place on the list.

Clients must agree to abstain from alcohol and drugs, other than prescribed and/or approved over-the-counter medications, while participating in all phases of the Treatment Program.

VANCOUVER HARBOUR LIGHT
GIVING • HOPE • TODAY

Preliminary Intake Assessment Form
Treatment Program (Update: December 2024)

Part 2: Applicant Information

For Office Use	
Date Application Received:	Date of Intake to Pre-Treatment:

Personal Information	
Full Name:	
Pronoun:	Gender:
Phone:	Date of Birth:
Email:	
Address:	
City, Province:	Postal Code:
*Please **do not** provide your Social Insurance Number (SIN) or Personal Health Number (PHN) on this form. If you are accepted into program, you may need to provide this information to access funding through social assistance and/or to access pharmacy services.*	
Do you have a Social Insurance Number (SIN)? ☐ No ☐ Yes	
Do you have a Personal Health Number (PHN)? ☐ No ☐ Yes	

Referring Agent	
Name:	Agency:
Phone:	Address:
Start Date of Service:	

Emergency Contact	
Name:	Relationship:
Phone:	Address:

Source of Income	
☐ Provincial Income Assistance (IA)	☐ Employment Insurance (EI)
☐ Provincial Disability Assistance (PWD)	☐ Canada Pension Plan (CPP)
☐ Employment	☐ Old Age Security (OAS)
☐ Other	

Education / Work Experience		
☐ Grade School (K – 7)	☐ Some high school	☐ High school or GED
☐ Trade school	☐ Some college/university	☐ College/university degree
☐ Other		
What work experience do you have?		

Part 3: Legal Information

Past Criminal Convictions		
Do you have a criminal record?	☐ Yes	☐ No
Please list your convictions:		
Do you have a history of sexual offences?	☐ Yes	☐ No
Do you have a history of violent crimes?	☐ Yes	☐ No

Upcoming Court Dates		
Do you have pending civil, family, traffic or criminal cases?	☐ Yes	☐ No
Please describe:		
Court Location:	Court Date(s):	

Legal Status		
Is treatment court-mandated?	☐ Yes	☐ No
Are you presently on probation?	☐ Yes	☐ No
Are you presently on parole?	☐ Yes	☐ No
If yes to any of the above, please list your conditions:		

Lawyer Contact		
Name:	Email:	
Phone:	Fax:	

Part 4: Substance Use & Treatment History

Treatment History		
Have you previously received counselling for your addiction?	☐ No ☐ Yes	
Do you currently have an addictions counsellor?	☐ No ☐ Yes *(please provide details below)*	
Name:	Phone:	
Agency/Office:		
Have you previously attended substance use treatment program(s)?	☐ No ☐ Yes *(please complete the chart below)*	
Dates	*Program*	*Did you complete?*
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
Have you ever been asked to leave a program?	☐ No ☐ Yes	
If yes, please explain why:		

Last Substance Use
When was the last time you used any drug(s) or drank alcohol?
What did you use?

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Substance Use History					
Substance	Method of Use *(e.g. smoke, snort, IV)*	Amount	Frequency	Age of First Use	Date Last Used
Alcohol					
Tobacco					
Marijuana					
Crack					
Cocaine					
Crystal Meth					
Heroin					
Fentanyl					
Ecstasy					
GHB					
Illicit Methadone					
Inhalants					
Benzodiazepines					
Prescription drug abuse					
Other:					

Opioid Agonist Therapy	
Are you currently on an opioid agonist therapy?	☐ No ☐ Yes *(please complete questions below)*
What are you taking?	☐ Methadone ☐ Suboxone ☐ Kadian ☐ Other:
How long have you been on opioid agonist therapy?	
What is your current dose?	
Who is the prescribing physician?	Physician's Phone:

Please note: *OAT medications are delivered and dispensed daily by our pharmacy at 8:15AM. We cannot accommodate PRN OAT medications.*

Additional Challenges	
Have you ever struggled with any of the following?	
Sex Addiction ☐ No ☐ Yes	Grief & Loss ☐ No ☐ Yes
Problem Gambling ☐ No ☐ Yes	Other – please explain:

Part 5: Family Background

Family Background	
Do you have any sisters?	☐ No ☐ Yes *How many?*
Do you have any brothers?	☐ No ☐ Yes *How many?*
Are you adopted?	☐ No ☐ Yes
Did you spend time in foster care?	☐ No ☐ Yes
Are there any signs of alcoholism, heavy drinking, or substance use among your family members?	☐ No ☐ Yes
If yes, please explain:	

Relationship Status	
What is your current marital status?	☐ Single ☐ Married ☐ Common-Law ☐ Divorced ☐ Widowed ☐ Other:
How would you assess your current relationship?	☐ Good ☐ Indifferent ☐ Bad ☐ Other:

Family Status	
Do you have any daughters?	☐ No ☐ Yes *How many?*
Do you have any sons?	☐ No ☐ Yes *How many?*
Who is taking care of your child(ren) right now?	☐ Spouse / partner ☐ Family member ☐ Foster care ☐ N/A ☐ Other:

Social Worker	
Name:	Phone:
Agency/Office:	

Part 6: Physical Health

Medical Care Provider	
Do you currently have a doctor?	☐ No ☐ Yes *(please complete the chart below)*
Name:	Phone:
Agency/Office:	

Medical History		
Do you have any medical diagnoses?	☐ No ☐ Yes	
If yes, please list:		
Are you currently taking any medications?	☐ No ☐ Yes *(please complete the chart below)*	
Diagnosis	*Medication(s)*	*Dosage*
Have you been hospitalized in the last year?	☐ No ☐ Yes	
If yes, please explain why:		
Do you have any allergies?	☐ Food ☐ Drugs ☐ Environment ☐ Other:	
If yes, please provide details:		
Do you have any communicable diseases?	☐ TB ☐ HIV ☐ Hep A, B, or C ☐ Other:	
If yes, please provide details:		
Have you been tested for TB in the last year?	☐ No ☐ Yes	
Name of clinic/facility where test was conducted:		

IMPORTANT: TB Testing
In addition to this Preliminary Intake Assessment Form, you **must** provide the Intake Counsellor with recent TB test results *prior to entering treatment*. If TB testing is not offered through your Primary Care Provider, please speak with our Intake Counsellor to discuss TB testing options.

Part 7: Mental Health

Mental Health		
Do you have any psychiatric diagnoses?	☐ No ☐ Yes *(please complete questions below)*	
Please check all that apply:	☐ Depression ☐ Anxiety ☐ CPTSD/PTSD ☐ OCD	
Please list other psychiatric diagnoses:		
Are you currently taking any medications relating to your psychiatric health?	☐ No ☐ Yes *(please complete the chart below)*	
Diagnosis	*Medication(s)*	*Dosage*
Do you have a history of any of the following?	☐ Suicidal Ideation ☐ Self-harming behaviours ☐ Eating disorder(s) ☐ Fire-setting behaviours ☐ Self-injury	
Have you ever been hospitalized for psychiatric care?	☐ No ☐ Yes	
If yes, please explain why:		
When was the date of your most recent hospital stay?		
Do you have any other comments about your mental health?		

Mental Health Care	
Do you currently have a mental health care worker, mental health team, or psychiatrist?	☐ No ☐ Yes *(please complete the chart below)*
If you do not have one, would you like to be connected with a Mental Health Worker?	☐ Yes ☐ No
Community Mental Health Worker / Team	
Name:	Phone:
Agency/Office:	
Psychiatrist	
Name:	Phone:
Agency/Office:	

Part 8: Spirituality / Religion / Cultural Background

Spiritual / Religious Beliefs	
Do you have any spiritual/religious beliefs?	☐ Yes ☐ No
If yes, what are they?	
Do you have an active devotional life or other spiritual practices?	☐ Yes ☐ No

Spiritual / Religious History	
Was your family an influence on your spiritual/religious life?	☐ Yes ☐ No
If yes, please explain:	
How would you describe your experience with spirituality/religion?	☐ Positive ☐ Negative
Do you see a connection between your spiritual/religious life and substance use?	☐ Yes ☐ No
If yes, please explain:	

Cultural Background	
What is your cultural background?	
Do you self-identify as	☐ Indigenous ☐ First Nations ☐ Métis ☐ Inuit ☐ Prefer Not to Answer

Part 9: Program Readiness

Are you ready?
Is there anything that would prevent you from participating with community meals and/or household chores? ☐ No ☐ Yes
If yes, please explain:
Please list any challenges you've faced in the past, relating to your recovery:
What personal assets will aid you in your recovery?

Part 10: Letter of Introduction

Please write a letter introducing yourself and sharing why you would like to attend the Harbour Light Treatment Program.

Part 11: What to Bring to Harbour Light

Please note that all your belongings need to fit into a small wardrobe. Storage is limited, and excess belongings that do not fit into the space provided are not permitted.

PLEASE BRING:

- A list of ALL the belongings you are bringing into the facility
- New medication prescriptions from your physician (not filled, just the prescription)
- Comfortable casual clothing, including closed toed shoes and long pants
- Toiletries and other personal care items
- An alarm clock

DO NOT BRING:

- Drug paraphernalia or weapons
- Devices that access the internet, including portable movie players, TVs, or computers
- Clothing promoting drug or alcohol use, violence, sex, or inappropriate language
- Valuables or large sums of money