# Part 1: Instructions

**How to Apply**

1. Complete this Intake and Assessment Application Form.
2. Send your referral form to [**stabilization@harbourlightbc.com**](mailto:stabilization@harbourlightbc.com) by fax to 604-682-1673.
3. Phone our Stabilization Counsellor at **604-646-6817** within 24 hours to confirm that we received your form, and learn more about our intake process.

When you call our Stabilization Counsellor, they may ask some follow-up questions to better understand your individual needs. Incomplete forms will delay your application for Harbour Light’s program. *Please note:* all applicants must be 19 years or older.

**Waitlist**

Our stabilization program may have a waitlist. If you are on the waitlist, it is your responsibility to leave a phone message with the Stabilization 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.**

# Part 2: Applicant Information

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| **For Office Use** | |
| Date Application Received: | Date of Intake to Stabilization: |

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| --- | --- | --- | --- | --- |
| **Personal Information** | | | | |
| Full Name: |  | | | |
| 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 | | |

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

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| --- | --- | --- | --- | --- |
| **Treatment Centre Referral Information** | | | | |
| Treatment Centre Referred to : | |  | | |
| Date Entering Treatment : |  | | Treatment Centre Phone Number: |  |
| Follow up Required by Client: | | | | |

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| --- | --- | --- | --- |
| **Emergency Contact** | | | |
| Name: |  | Relationship: |  |
| Phone: |  | Address: |  |

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| **Source of Funding for Treatment Fees** |
| Social assistance (Welfare)  Employment Insurance (EI)  Employee Assistance Program (through work)  Canada Pension Plan (CPP)  Correctional Service of Canada (CSC)  Self-paying  Other |

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| **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

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| **Past Criminal Convictions** | |
| *Do you have a criminal record?* | Yes  No |
| Do you have a history of sexual offences? | Yes  No |
| Do you have a history of violent crimes? | Yes  No |

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| **Current / Pending Criminal Charges** | | | | |
| *Do you have pending civil, traffic or criminal cases?* | | Yes  No | | |
| Please list your charges: | | | | |
| Court Location: |  | | Court Date(s): |  |

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| **Legal Status** | |
| 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: | |

# Part 4: Substance Use & Treatment History

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| **Treatment History** | | | |
| Have you previously received counselling for your addiction? | | No  Yes | |
| 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 |

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| **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 | Date Last Used |
| Alcohol |  |  |  |
| Marijuana |  |  |  |
| Crack |  |  |  |
| Cocaine |  |  |  |
| Crystal Meth |  |  |  |
| Heroin |  |  |  |
| Fentanyl |  |  |  |
| Benzodiazepines |  |  |  |
| Prescription drug abuse |  |  |  |
| Other: |  |  |  |

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| **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: |

# Part 5: Physical Health

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

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| **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* |
|  |  | |  |
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| Do you have any allergies? | | Food  Drugs  Environment  Other: | |
| Have you had a TB Test done in the last year? | | Yes Results:  No | |

**IMPORTANT: TB Testing**

You can get a TB test done at the Downtown Community Health Centre at 569 Powell Street in Vancouver. Hours of operation are 8:30am-12:00pm on Mondays, Tuesdays, Thursdays, and Fridays.

# Part 6: Mental Health

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| **Mental Health** | | | |
| Do you have any psychiatric diagnoses? | | No  Yes *(please complete questions below)* | |
| Are you currently taking any medications relating to your psychiatric health? | | No  Yes  *(please complete the chart below)* | |
| *Diagnosis* | *Medication(s)* | | *Dosage* |
|  |  | |  |
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| Do you have a history of any of the following? | | Suicide attempts  Self-harming behaviours  Eating disorder(s)  Fire-setting behaviours | |

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| **Mental Health Care** | | | | |
| Do you currently have a mental health care worker, mental health team, or psychiatrist? | | No  Yes *(please complete the chart below)* | | |
| *Community Mental Health Worker / Team* | | | | |
| Name: |  | | Phone: |  |
| Agency/Office: |  | |  | |
| *Psychiatrist* | | | | |
| Name: |  | | Phone: |  |
| Agency/Office: |  | |  | |

# Part 7: Spirituality / Religion

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| --- | --- |
| **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 |