



Part 1: Instructions

How to Apply

1. Complete this Intake and Assessment Application Form.
2. Send your referral form to 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

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

Personal Information	
Full Name:	
Phone:	Date of Birth:
Email:	
Address:	
City, Province:	Postal Code:
<i>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.</i>	
Do you have a Social Insurance Number (SIN)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a Personal Health Number (PHN)?	<input type="checkbox"/> No <input type="checkbox"/> Yes

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

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

Emergency Contact	
Name:	Relationship:
Phone:	Address:



Source of Funding for Treatment Fees	
<input type="checkbox"/> Social assistance (Welfare)	<input type="checkbox"/> Employment Insurance (EI)
<input type="checkbox"/> Employee Assistance Program (through work)	<input type="checkbox"/> Canada Pension Plan (CPP)
<input type="checkbox"/> Correctional Service of Canada (CSC)	<input type="checkbox"/> Self-paying
<input type="checkbox"/> Other	

Education / Work Experience		
<input type="checkbox"/> Grade School (K – 7)	<input type="checkbox"/> Some high school	<input type="checkbox"/> High school or GED
<input type="checkbox"/> Trade school	<input type="checkbox"/> Some college/university	<input type="checkbox"/> College/university degree
<input type="checkbox"/> Other		
What work experience do you have?		

Part 3: Legal Information

Past Criminal Convictions	
Do you have a criminal record?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of sexual offences?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of violent crimes?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Current / Pending Criminal Charges	
Do you have pending civil, traffic or criminal cases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list your charges:	
Court Location:	Court Date(s):

Legal Status	
Are you presently on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you presently on parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to any of the above, please list your conditions:	



Part 4: Substance Use & Treatment History

Treatment History		
Have you previously received counselling for your addiction? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Have you previously attended substance use treatment program(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete the chart below)</i>		
Dates	Program	Did you complete?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Substance Use History			
Substance	Method of Use <i>(e.g. smoke, snort, IV)</i>	Amount	Date Last Used
Alcohol			
Marijuana			
Crack			
Cocaine			
Crystal Meth			
Heroin			
Fentanyl			
Benzodiazepines			
Prescription drug abuse			
Other:			



Opioid Agonist Therapy	
Are you currently on an opioid agonist therapy?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete questions below)</i>
What are you taking?	<input type="checkbox"/> Methadone <input type="checkbox"/> Suboxone <input type="checkbox"/> Kadian <input type="checkbox"/> 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

Medical Care Provider	
Do you currently have a doctor?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete the chart below)</i>
Name:	Phone:
Agency/Office:	

Medical History		
Do you have any medical diagnoses?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, please list:		
Are you currently taking any medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete the chart below)</i>	
Diagnosis	Medication(s)	Dosage
Do you have any allergies?	<input type="checkbox"/> Food <input type="checkbox"/> Drugs <input type="checkbox"/> Environment <input type="checkbox"/> Other:	
Have you had a TB Test done in the last year?	<input type="checkbox"/> Yes Results: <input type="checkbox"/> 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

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

Mental Health Care	
Do you currently have a mental health care worker, mental health team, or psychiatrist? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>please complete the chart below</i>)	
Community Mental Health Worker / Team	
Name:	Phone:
Agency/Office:	
Psychiatrist	
Name:	Phone:
Agency/Office:	



Part 7: Spirituality / Religion / Cultural Background

Spiritual / Religious Beliefs	
Do you have any spiritual/religious beliefs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what are they?	
Do you have an active devotional life or other spiritual practices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cultural Background	
What is your cultural background?	
Do you self-identify as	<input type="checkbox"/> Indigenous <input type="checkbox"/> First Nations <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/> Prefer Not to Answer