# Part 1: Instructions

**How to Apply**

1. Complete this Preliminary Intake Assessment Form.
2. Send your referral form to[**VancouverHL.TreatmentIntake@salvationarmy.ca**](mailto:VancouverHL.TreatmentIntake@salvationarmy.ca) or by fax to 604-682-1673.
3. Phone our Intake Counsellor at **604-646-6856** within 24 hours to confirm that we received your form, and learn more about our intake process.

When you call our Intake Counsellor, they 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.**

# Part 2: Applicant Information

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

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

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

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

|  |
| --- |
| **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 |
| Details: |
| **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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current / Pending Criminal Charges** | | | | |
| *Do you have pending civil, traffic or criminal cases?* | | Yes  No | | |
| Please list your charges: | | | | |
| 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? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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: |

|  |  |
| --- | --- |
| **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  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: | | | |

**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*. 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.Your test results should be faxed to the attention of the Intake Counsellor at 604-682-1673.

# 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  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? | | Suicide attempts  Self-harming behaviours  Eating disorder(s)  Fire-setting behaviours | |
| 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