



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.



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:
<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:	

Emergency Contact	
Name:	Relationship:
Phone:	Address:

Source of Income	
<input type="checkbox"/> Provincial Income Assistance (IA)	<input type="checkbox"/> Employment Insurance (EI)
<input type="checkbox"/> Provincial Disability Assistance (PWD)	<input type="checkbox"/> Canada Pension Plan (CPP)
<input type="checkbox"/> Employment	<input type="checkbox"/> Old Age Security (OAS)
<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
Please list your convictions:	
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

Upcoming Court Dates	
Do you have pending civil, family, traffic or criminal cases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe:	
Court Location:	Court Date(s):

Legal Status	
Is treatment court-mandated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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:	

Lawyer Contact		
Name:	Email:	
Phone:	Fax:	



Part 4: Substance Use & Treatment History

Treatment History		
Have you previously received counselling for your addiction? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Do you currently have an addictions counsellor? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please provide details below)</i>		
Name:		Phone:
Agency/Office:		
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
Have you ever been asked to leave a program? <input type="checkbox"/> No <input type="checkbox"/> 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 <i>(e.g. smoke, snort, IV)</i>	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?	<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:

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 <input type="checkbox"/> No <input type="checkbox"/> Yes	Grief & Loss <input type="checkbox"/> No <input type="checkbox"/> Yes
Problem Gambling <input type="checkbox"/> No <input type="checkbox"/> Yes	Other – please explain:

Part 5: Family Background

Family Background	
Do you have any sisters?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>How many?</i>
Do you have any brothers?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>How many?</i>
Are you adopted?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did you spend time in foster care?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any signs of alcoholism, heavy drinking, or substance use among your family members?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please explain:	

Relationship Status	
What is your current marital status?	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other:
How would you assess your current relationship?	<input type="checkbox"/> Good <input type="checkbox"/> Indifferent <input type="checkbox"/> Bad <input type="checkbox"/> Other:

Family Status	
Do you have any daughters?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>How many?</i>
Do you have any sons?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>How many?</i>
Who is taking care of your child(ren) right now?	<input type="checkbox"/> Spouse / partner <input type="checkbox"/> Family member <input type="checkbox"/> Foster care <input type="checkbox"/> N/A <input type="checkbox"/> Other:

Social Worker	
Name:	Phone:
Agency/Office:	



Part 6: 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
Have you been hospitalized in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, please explain why:		
Do you have any allergies? <input type="checkbox"/> Food <input type="checkbox"/> Drugs <input type="checkbox"/> Environment <input type="checkbox"/> Other:		
If yes, please provide details:		
Do you have any communicable diseases? <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Hep A, B, or C <input type="checkbox"/> Other:		
If yes, please provide details:		
Have you been tested for TB in the last year? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete questions below)</i>		
Please check all that apply: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> CPTSD/PTSD <input type="checkbox"/> OCD		
Please list other psychiatric diagnoses:		
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"/> Suicidal Ideation <input type="checkbox"/> Self-harming behaviours <input type="checkbox"/> Eating disorder(s) <input type="checkbox"/> Fire-setting behaviours <input type="checkbox"/> Self-injury		
Have you ever been hospitalized for psychiatric care? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete the chart below)</i>	
If you do not have one, would you like to be connected with a Mental Health Worker? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<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

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

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



Part 9: Program Readiness

Are you ready?
Is there anything that would prevent you from participating with community meals and/or household chores? <input type="checkbox"/> No <input type="checkbox"/> 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