



Supportive Recovery Program  
Referral Package Checklist

Please ensure all sections of this referral package are completed in entirety and submitted together to [intake@thresholdhousing.ca](mailto:intake@thresholdhousing.ca).

Date:	
Youth Name:	
Referring Agency:	
<ul style="list-style-type: none"><li><input type="checkbox"/> Checklist</li><li><input type="checkbox"/> Application Form</li><li><input type="checkbox"/> Release of Information</li><li><input type="checkbox"/> Guidelines and Standards</li><li><input type="checkbox"/> Consent for Services</li><li><input type="checkbox"/> Childhood Immunization Status</li><li><input type="checkbox"/> Early Exit Plan</li><li><input type="checkbox"/> Exemption Consent Form (For Minors Only)</li></ul>	



**THRESHOLD**  
HOUSING SOCIETY

**SUPPORTIVE RECOVERY PROGRAM  
APPLICATION FORM**

<b>Referrer Information</b>	
Name:	
Date:	
Agency:	
Email:	
Phone Number:	
Reason for Referral:	

<b>Youth Applicant Information</b>	
Name:	
Pronoun:	
Gender Identity:	
Cultural Identity:	
Languages spoken:	
Age:	
Birthday:	



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Applying from:	Westshore – Colwood/Langford/Sooke Victoria/South Island Mid-Island North Island		
Enrolled in school:	Yes No		
Employed:	Yes No		
Describe the applicant's daily schedule:			
Current Address:			
Phone Number:			
Email:			
Legal Guardian:	Name:	Contact Information:	Relationship:
Emergency Contact:	Name:	Contact Information:	Relationship:



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**Program Goals**

What are the applicant's goals in a supportive recovery program?

How are they best supported with these goals?

What are the applicant's strengths?

What challenges does this applicant experience?



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Are there family members that are important to the applicant that they would like involved as part of treatment planning or aftercare planning?

### Current Housing

Describe the applicant's current housing situation:

Is there a post-program housing plan?



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**Medical History**

List all medical diagnoses:

Attention Deficit Disorder  
Attention Deficit Hyperactivity Disorder  
Reactive Attachment Disorder  
Fetal Alcohol Spectrum  
Psychosis  
Eating Disorder  
Mood Disorder  
Post-Traumatic Stress Disorder  
Complex Post-Traumatic Stress Disorder  
Family History of Mental Health Diagnoses  
Family History of Substance Use

Obsessive-Compulsive Disorder  
Oppositional Defiant Disorder  
Borderline Personality Disorder  
Bi-Polar Spectrum  
Depression  
Anxiety  
Learning Disability  
Developmental Disability  
Neurological Disability  
Autism Spectrum  
Other (Please specify)

List any allergies:

List all medications and dosages:

List all medical contacts:

Vaccinations and Immunizations:

COVID-19 Vaccinations  
Childhood Immunizations  
Recent Flu Shot  
Recent Tuberculosis Screening



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Substance Use History								
Applicant has a History with:		Age of 1 <sup>st</sup> Use	Current Pattern of Use	Date of Last Use	# of Days Used in the last 30 Days	Route Taken (Intravenous, Smoke, etc.)	Average Amount Used Daily	Goals for this Substance
	<i>Example: Cannabis</i>	15	3x daily	Jan 1 2021	30	Smoke	1 gram	Only use on weekends
	Alcohol							
	Non-beverage Alcohol (Listerine, rubbing alcohol, etc.)							
	Amphetamines (Dexedrine, Adderall, etc.)							
	Ecstasy (MDMA, MDA, etc.)							
	GHB							
	Benzodiazepines							
	Cannabis							
	Cocaine							
	Crack							
	Crystal Meth							
	Fentanyl							

\*Please circle substances applicant is currently seeking support with.



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	Applicant has a History with:	Age of 1 <sup>st</sup> Use	Current Pattern of Use	Date of Last Use	# of Days Used in the last 30 Days	Route Taken (Intravenous, Smoke, etc.)	Average Amount Used Daily	Goals for this Substance
	Heroin							
	Oxycodone/ Oxycontin							
	Morphine/ Codeine							
	Kratom							
	Hydromorphone/ Dilaudid							
	O.A.T. (Suboxone, Methadone, Kadian)							
	Psilocybin							
	DMT							
	LSD							
	Inhalants (Gasoline, Nitrous Oxide, Poppers, etc.)							
	Prescriptions							
	Tobacco							
	Vaping							
	Other (Specify)							

\*Please circle substances applicant is currently seeking support with.





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Process Addictions				
Applicant has a History with:	Current Pattern	Date Last Active	# of Days Active in the last 30 Days	Age of 1 <sup>st</sup> Use
	Gambling			
	Sexual Activity			
	Pornography			
	Shopping			
	Shoplifting			
	Internet			
	Social Media			
	Video Games			
	Exercise			
	Other (Specify)			

Overdose History	
Has the applicant ever overdosed? If yes, complete the section below.	Yes      No
Was the overdose(s) accidental or intentional?	



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How many times have you overdosed?	
What substances were used?	
Where were you?	
Was naloxone administered?	
Was hospital admission required?	
Please provide any other information about the overdose event(s) that the applicant would feel is relevant to support them.	

Treatment History		
Withdrawal Management/Detox/Stabilization	Date/Details:	
Substance Use Community Groups (AA/NA/Smart Recovery)	Date/Details:	
Counsellor, Peer Support, Social Worker, Outreach Worker, etc.	Date/Details:	
Residential Treatment Programs <i>(provide details below)</i>		
Program Name:	Dates Attended:	Completed Program?
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No



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Any other substance-use related resources the applicant has engaged with:	
What are some things the applicant liked, found helpful or useful from previous substance use resources?	
What are some things the applicant did not like, did not find helpful or useful from previous substance use resources?	
Why is Threshold's Supportive Recovery Program being considered at this time?	

Safety Concerns	
List any cause for safety concerns:	
Self-Harming Behaviour Suicidal Ideation Suicide Attempt Flight Risk Arson/Fire-setting Interpersonal Violence	Sexual Offence Involving a Minor Physical Aggression Verbal Aggression None Other (please specify)
What form of intervention is most effective?	



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Community Supports		
Name:	Contact Info:	Relationship:

Is there any other information you would like to provide that would help us better support this applicant?



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HOUSING SOCIETY

**Supportive Recovery Program  
Release of Information**

**The following must be completed by youth applicant.**

I, \_\_\_\_\_, consent to the Threshold Housing Society (THS) Supportive Recovery Program to contact, communicate and release information regarding myself to the authorized organizations and people listed below.

I consent to the release of information between the client support team at Threshold Housing Society.

I understand that I can withdraw my permission at anytime.

I understand that I do not have to sign this consent form.

This form will be valid until my file is closed at the THS Supportive Recovery Program.

People and Organizations	Goals	Progress Report	Legal Status	Substance Use	All	Other (Specify)

<b>Participant Signature:</b>	
<b>Name:</b>	
<b>Date:</b>	

## Guidelines and Standards for Supportive Recovery

Below are the expectations that SRP has for all youth. If these expectations are not followed, staff will speak with you about the behaviors. This could result in receiving a warning letter or being asked to leave the program. Please initial beside each one after reading through.

- I will treat staff and other participants with fairness, honesty and respect including keeping information about other participants confidential, avoid all activity that might harm other youth, staff or visitors and follow SRP guidelines.
- I will always use respectful communication. I will not yell, scream, or raise my voice when speaking with staff or other participants. I will not bully, make threats of violence, sexually harass, or become violent with other youth, staff, or visitors.
- I will not possess weapons such as blades, knives, brass knuckles, crow bars or anything else that could be used to harm someone. If you possess any weapons they will be removed immediately and stored until discharge. They will not be returned prior to discharge.
- I will meet with SRP staff for one-on-one meetings weekly and I will engage with staff to work on all goals set in my case plan.
- I will attend all recovery groups and programming. These activities are not optional. If you believe you need to miss a group or program, you must first speak with your case manager for that to be approved. Failure to participate in programs may result in being asked to leave the program.
- I will not share the address and location of the Supportive Recovery Program.
- I will not enter other participant bedrooms and private spaces; communal spaces are located on the main floor and backyard.
- I will not share, sell, or distribute substances of any kind while in the program.**
- I will not purchase substances near or on the program property.**
- I will remain abstinent from alcohol &/or substances during groups and outings.**
- I will not consume substances inside the program, residential spaces, or host family home. Including all tobacco, cannabis, or nicotine products.**
- I will be honest with staff about my substance use.**
- I will use the designated smoking area.

- I will complete a pass with staff prior to leaving the property. If you leave the property without a pass/staff permission, or you do not return when your pass expires, you will be considered AWOL and staff will complete a Missing Person's Report with the police.
- I will follow expectations around the program schedule, curfew, groups, and outings.
- I will allow all medications to be dispensed by staff.
- I will keep my living space, and communal space clean. Staff will remind/support around maintaining cleanliness if necessary.

<b>Participant Signature:</b>	
<b>Name:</b>	
<b>Date:</b>	



## CONSENT FOR SERVICES

Threshold Housing Society Supportive Recovery Program offers live in and host family accommodations, recovery and life skills programming and support as well as counselling services for up to 120 days. All services are voluntary, and you can stop programming at any time. We strive to be client-directed and encourage you to give us feedback and ask any questions you might have.

## CONFIDENTIALITY

We wish to ensure you understand the limits of confidentiality we are bound by. Please know that your personal information is kept confidential and will not be shared without your consent, except when:

- If we obtain information which leads us to suspect that a child (18 and under) is at risk for, or has been, physically abused, sexually abused, emotionally abused, or neglected, we are legally obliged to make a report to the Ministry for Children & Family Development. We can make this call with you. This is about protecting children from harm.
- If you inform us about any intent to commit an act which could result in the injury or death of another/others, we are legally obliged to contact the police. This is about protecting others from harm.
- If we have concerns that you are a danger to yourself, she/he will discuss with you any plan that they may need to take on your behalf (e.g. call a family member or family physician). However, in situations where we are unable to discuss this with you, they may need to proceed without your consent in order to fulfill their obligation to ensure your safety.
  - Subpoena.
  - Knowledge of a crime that was or is about to be committed.
- All information gathered is subject to the *Freedom of Information and Protection of Privacy Act (FOIPPA)* as well as *Island Health's policy on confidentiality*.
- Some of the information you provide will be kept in your file electronically or paper format. You can make a formal request to see this information as per the *FOIPPA* requirements.
- Any information we use for statistical reporting purposes will be completely anonymous.
- If participating in online video counselling, you are aware of risks to privacy and confidentiality and have provided an alternative back up contact information (phone number and location).
- If you are participating in a group, we expect you to observe confidentiality regarding the information shared in the group sessions.
- I consent to participate in the services available through *Threshold Housing Society Supportive Recovery Program*.





**AMBULANCE TRANSFER AND MEDICAL ATTENTION**

In the event of a medical emergency, emergency services will be dispatched. This may include, but is not limited to, being transported to hospital by an ambulance.

**COMMUNICATIONS**

I request and authorise *Threshold Housing Society Supportive Recovery Program* to communicate with me regarding the logistics of my care (such as meetings, contact when I am offsite) via my email address and/or mobile phone number.

I acknowledge email and text messaging is generally not secure and *Threshold Housing Society* does not recommend it for the transmission of personal or other confidential information. \_\_\_\_\_ (client initial).

**My consent and agreement are valid for the duration of this program, but no longer than two years without renewal, following the date of signing below.**

<b>Signature:</b>	
<b>Name:</b>	
<b>Date:</b>	

### Childhood Immunization Status

The BC government recommends the following vaccinations to be completed during childhood:

- DTaP-HB-IPV-HIB (Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Haemophilus Influenza Type B)
- Pneumococcal Conjugate
- Rotavirus
- Meningococcal C Conjugate
- MMR (Measles, Mumps, Rubella)
- Influenza

I, \_\_\_\_\_, declare that to best of my knowledge most or all of  
(Doctor, Parent, Participant)

\_\_\_\_\_ vaccinations included in BC's immunization schedule  
(Participant)

HAVE,  HAVE NOT,  UNSURE IF been completed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Early Exit Plan for Supportive Recovery Program**

On occasion, a participant may choose to leave the program early or be asked to leave due to safety reasons. In the event of an early exit, participants and their families/supports are requested to have an early exit plan.

Provide instructions below to be followed in the event of an unexpected discharge from the Supportive Recovery Program, including name, relationship to participant, contact information and early exit location. If possible, please provide a secondary contact.

In the event of an unexpected discharge from the Supportive Recovery Program,

I, \_\_\_\_\_, understand the expectations of this form and I am  
(Support/Guardian)  
 agreeable to the plan for \_\_\_\_\_ to discharge into my care.  
(Participant)

In the event of an unexpected discharge from the Supportive Recovery program staff will make attempts to find a safe resource for the participant. I, \_\_\_\_\_, understand that if no plan is provided \_\_\_\_\_ may be discharged to a community shelter.  
(Participant/Support/Guardian)  
(Participant)

Participant Name	Participant Signature	Date
Support/Guardian Name	Support/Guardian Signature	Date



## Statement of Consent for Exemption Application

Threshold Housing Society's (THS) Supportive Recovery Program is an Island Health licensed facility. The license has been issued for participants over the age of 19, however, the program is available to participants between the ages of 15-21. This form only needs to be filled out if an applicant will be under 19 at the time of entering the Supportive Recovery Program.

In some cases, accommodations may be required to be double occupancy. As a safeguard, all participants below the age of 19 will have accommodations on the top floor of the program space, and all participants 19+ will have accommodations on the bottom floor of the program.

In order to accept participants under the age of 19 into the program, THS must submit an exemption request to Island Health on the participants behalf prior to their acceptance. The following statement of consent can be completed by a medical professional, parent, and/or a legal guardian and will be submitted with the exemption request.

I \_\_\_\_\_ consent to an exemption being submitted  
(Name and Relation to Participant)

on the behalf of \_\_\_\_\_ and understand that other program  
(Participant)

participant ages will vary between the ages of 15-21.

I \_\_\_\_\_ do not consent to an exemption being  
(Name and Relation to Participant)

submitted on the behalf of \_\_\_\_\_.  
(Participant)

Participant Name	Participant Signature	Date
Support/Guardian Name	Support/Guardian Signature	Date