



Client Name: _____

PHN: _____

INITIAL APPLICABLE BOXES

REFERRAL AND PROGRAM INFORMATION

Date of Referral: _____		Is this a self-referral? ☐ No ☐ Yes	
Referring Most Responsible Practitioner (MRP)	Name: _____		
	Agency / Organization: _____		
	Phone: _____		
	Email: _____		
Specific recovery treatment centre requested? ☐ No ☐ Yes (specify): _____			
Secondary Preference: _____			
Third Preference: _____			
Client is aware of and consents to this referral being submitted. ☐ No ☐ Yes			

CLIENT DEMOGRAPHICS

Legal Last Name: _____	Legal First Name: _____	Preferred Name: _____
Date of Birth (MMM-DD-YYYY): _____	Gender: _____	Personal Health Number (PHN): _____
Mailing Address: _____		City / Town: _____
Postal Code: _____	Primary Phone: _____	
Alternate Contact Person and Phone or Email: _____		
Emergency Contact Name, Relationship, and Phone: _____		

PRESENTING CONCERN / REASON FOR REFERRAL

Please describe the reason for this referral. What is happening right now?

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SUBSTANCE USE PROFILE

Substance(s) of Choice (primary / secondary / tertiary):

Substance	Substance use	How important is it to you to change/stop using? Choose one: Not at all, Somewhat, or Very Important
Alcohol	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Heroin, fentanyl, other non-prescribed opioid	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Prescription Opioid	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Benzodiazepines/sleeping medication	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Cocaine/crack	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Methamphetamine	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Prescribed Stimulant	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Cannabis/marijuana	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Nicotine/tobacco	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important
Other: _____	☐ No ☐ Yes	☐ Not at all ☐ Somewhat ☐ Very Important

PROCESS ADDICTIONS / OTHER BEHAVIOURAL CONCERNS

Are gambling, gaming, sex/pornography, shopping, or other behavioural addictions also present?

☐ No ☐ Yes: briefly describe:

WITHDRAWAL AND INTOXICATION HISTORY

Have you / the client experienced withdrawal symptoms (shakes, sweats, nausea, hallucinations, seizures, Delirium Tremens [DTs])?

☐ No ☐ Yes: Where and when, and were you treated by a medical practitioner?

History of seizures related to withdrawal or substance use.	☐ No ☐ Yes
History of delirium tremens (DTs) or ICU admission due to withdrawal.	☐ No ☐ Yes
Have you / the client ever needed emergency care for a substance-use-related illness or overdose?	☐ No ☐ Yes



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BIOMEDICAL / HEALTH

Current medical conditions (chronic illness, recent surgery, injuries, pain, lice, bed bugs, etc.):

Current Medications

Medication	Dose	Frequency	Prescriber

Currently on Opioid Agonist Therapy (Suboxone, Methadone) or other addiction medicine treatment?

☐ No ☐ Yes: List current Opioid Agonist Therapy prescriber:

Known allergies (drug, food, environmental)

☐ No known Allergies ☐ Yes: please list:

Currently pregnant (If yes, due date and physician monitoring client)

☐ N/A ☐ No ☐ Yes: Estimated due date? _____ Physician monitoring: _____

Physically able to safely participate in daily program activities (chores, lifting, mobility) ☐ Yes ☐ No

MENTAL HEALTH

Current or past mental health diagnoses

☐ No ☐ Yes (Specify):

Currently being treated for a mental health condition(s)

☐ No ☐ Yes

Hospitalizations for mental health (If yes, year and reason for admission)

☐ No ☐ Yes (year and reason for admission):

Current thoughts of self-harm or suicide

☐ No ☐ Yes

Past self-harm or suicide attempts (please specify)

☐ No ☐ Yes

Any risk of harm to others

☐ No ☐ Yes

Trauma History — this is a brief screen only. The client decides how much to share at this stage; a fuller trauma history belongs to the receiving program once trust and safety are established.

Is there any known trauma history relevant to treatment planning? ☐ Client declined to answer

☐ No ☐ Yes (specify, if patient willing to share):

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Known impact of residential schools or intergenerational trauma (self or family) ☐ Client declined to answer
☐ No ☐ Yes

What are some of the client's strengths, resiliency, and protective factors (supports, coping skills, motivation, cultural or spiritual connection)?

TREATMENT AND RECOVERY HISTORY

Has the client attended treatment before?

☐ No ☐ Yes (*fill in treatment history below*)

Treatment Centre / Program	Approximate Date	Completed? (Y/N)	Length of Abstinence or Reduced Use After Treatment

Known relapse triggers or patterns (if known)

RECOVERY ENVIRONMENT

Current Living Situation:

Stable housing to return to after treatment ☐ No ☐ Yes

Currently living with anyone who also uses substances ☐ No ☐ Yes

Support system (family, friends, community, workers) available to the client:

Does the client have childcare arrangements for any dependents in the home?

☐ No ☐ Yes ☐ Not Applicable

LITERACY AND ACCESSIBILITY NEEDS

Support needed with reading or writing: ☐ No ☐ Yes

Mobility, hearing, vision, or other accommodation needs (self-care: requires support dressing or bathing)

☐ No ☐ Yes (describe briefly):

LEGAL MATTERS

Current charges, probation, parole, or other legal conditions:

☐ No ☐ Yes (describe):

Probation / Parole Officer Name and Contact:

Upcoming Court Dates:



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PRACTICAL / LOGISTICS

Funding Source (Income Support, SAID, Treaty/NIHB, Private, etcetera) and purpose during treatment (medication, personal hygiene, etcetera):

Does the client have access to their own transportation to treatment?

☐ No ☐ Yes

Upcoming appointments the program should be aware of when scheduling:

Client/Substitute Decision Maker (SDM) Signature

Client/SDM Statement: I authorize the information on this form to be shared with the Saskatchewan Health Authority Provincial Navigation Team and Saskatchewan Health Authority affiliated recovery treatment centres to coordinate my treatment. I understand the purpose of this disclosure, the risks and benefits of consenting to or refusing the disclosure of this health information, and that I may withdraw my consent at any time. I am providing this consent voluntarily and without coercion.

X

*Signature of client or *substitute decision maker*

SDM Printed Name

Date (mm/dd/yyyy)

***If consent is being provided by a Substitute Decision Maker (SDM), the SDM initials below the basis of authority based on *The Health Care Directives and Substitute Decision Makers Act, 2015*:**

- ☐ Proxy appointed under a health care directive
☐ A personal guardian appointed under *The Adult Guardianship and Co-decision-making Act*
☐ Nearest relative (where no proxy or guardian is appointed or available) – Relationship: _____

☐ **Verbal Consent** – only if impossible to get signature - Rationale: _____

☐ **Telephone/Virtual Consent** – Client identity verified by 2 unique identifiers (example: client's first/last name and birthdate). MRP/Designate to print the name of the client providing consent above in the signature spot OR, if an SDM, print the name of the SDM and complete the SDM Section to indicate the basis of authority.

Most Responsible Practitioner (MRP)/Designate Statement and Signature

Practitioner Attestation: I have explained to the client that the health information collected on this form may be disclosed to the Saskatchewan Health Authority Provincial Navigation Team and Saskatchewan Health Authority affiliated recovery treatment centres to coordinate treatment. I have explained the risks and benefits of consenting to or refusing the disclosure and answered the client's/SDM's questions. In my opinion, the client/SDM has the capacity to consent and understands the information provided.

Full Name of MRP or Authorized Designate (*first and last name*)

Signature

Date (mm/dd/yyyy)