

# The Cedars

Addictions Treatment for Young Women from 13 to 18 years of age

## Referral Package

### Personal Information

Name: \_\_\_\_\_ Date Of Birth (M/D/Y): \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ OK to leave message? Y \_\_\_ N \_\_\_

Parent Name: \_\_\_\_\_

If not residing with parent Legal Guardian / Caregiver: \_\_\_\_\_

Telephone: \_\_\_\_\_

BC Care Card Number: \_\_\_\_\_

### Professional Contacts

A & D Counsellor: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Other Professional Contacts

Name / Relationship: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Name / Relationship: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Name / Relationship: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

### Medical History

Doctors Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Last medical exam (approx.): \_\_\_\_\_

Present Medical Concerns: \_\_\_\_\_

(Ex: asthma, allergies, diabetes, hepatitis C, HIV)

Current medication: \_\_\_\_\_

(name of doctor or psychiatrist who prescribed the medication, report will be required)

Current Health Concerns: Y \_\_\_ N \_\_\_ Explain: \_\_\_\_\_

Pregnant: Y \_\_\_ N \_\_\_ If yes, how far along: \_\_\_\_\_

### History of Substance Use

Substance	Age of First Use	How many days have you misused in the last 30 days?	Have you ever misused so much that you became ill?	The date of your last use
Alcohol				
Cannabis (Pot)				
Cocaine				
Hallucinogens				
Heroin				
Amphetamines				
Other				

\*Circle drug of choice

Have you used drugs or alcohol before or during school? Y \_\_ N \_\_

Have you missed school or work because of substance use? Y \_\_ N \_\_

Have you used substances more than 3 days in a row? Y \_\_ N \_\_

When did you last use? \_\_\_\_\_

Have you ever used drugs intravenously? Y \_\_ N \_\_

Have you noticed your drug use becoming more frequent? Y \_\_ N \_\_

Explain: \_\_\_\_\_  
 \_\_\_\_\_

Has anyone told you to cut down or stop using drugs? Y \_\_ N \_\_

Have you ever tried to stop using drugs before? Y \_\_ N \_\_

If yes what did you do? Detox: Y\_\_ N\_\_ Residential: Y\_\_ N\_\_ Outpatient: Y \_\_ N \_\_

12-Step Programs: Y\_\_ N\_\_ Other: Y\_\_ N\_\_

Explain: \_\_\_\_\_

How are drugs affecting your life? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

### Legal History

Have you ever been charged with an offense? Y \_\_\_ N \_\_\_

Explain (ex: assault, alcohol-related charges, breach of probation, dangerous driving, shoplifting, trafficking, weapons): \_\_\_\_\_

Have you ever been convicted? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

Are there any outstanding charges against you? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

Any upcoming court dates? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

Are you currently on probation? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

### Education

Are you currently enrolled in school? Y \_\_\_ N \_\_\_

If yes, school name: \_\_\_\_\_ Grade: \_\_\_\_\_

If no, please choose one of the following:

Graduated: Y \_\_\_ N \_\_\_ Expelled: Y \_\_\_ N \_\_\_ Choosing not to attend: Y \_\_\_ N \_\_\_

Last grade completed was: \_\_\_\_\_

Last school attended was: \_\_\_\_\_

Have you ever skipped classes or been suspended: Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

### Family and Social Support

Where are you currently living? \_\_\_\_\_

Are you satisfied with your living situation? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

Do you have brother(s) or sister(s)? Y \_\_\_ N \_\_\_ Do they live with you? Y \_\_\_ N \_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Any additional comments: \_\_\_\_\_

\_\_\_\_\_

Who do you consider as supportive people in your life? \_\_\_\_\_

Who do you have that listens to you and understands how you feel about things that are important to you? \_\_\_\_\_

**Psychological History**

Have you ever sought help from any of the following (please check one):

Psychologist \_\_\_ Psychiatrist \_\_\_ Mental Health worker \_\_\_  
Therapist \_\_\_ Other \_\_\_

Explain: \_\_\_\_\_

Have you ever experienced any of the following?

Anger problems \_\_\_ Flashbacks \_\_\_ Panic attacks \_\_\_  
Anxiety or tension \_\_\_ Hallucinations \_\_\_ Unhappy with yourself \_  
Depression \_\_\_ Loneliness \_\_\_ Other \_\_\_

Explain: \_\_\_\_\_

Have you ever been prescribed medication for any of the above concerns? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

Have you had individual or group counseling before? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

If yes, what did you find helpful or not helpful?

Explain: \_\_\_\_\_

Do you think about harming yourself? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

When was the last time you thought about harming yourself? \_\_\_\_\_

Have you ever harmed yourself? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

Do you think about suicide? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

When was the last time you thought about suicide? \_\_\_\_\_

Have you ever attempted suicide? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

### Additional Information

What is your motivation for seeking treatment at this time?

Explain: \_\_\_\_\_

Is there anything you would like us to know about you that would help us to get to know you? For example, do you have any hobbies, pets, preferred activities, and favorite foods, or type of music?

\_\_\_\_\_

Is there anything we have not asked that you feel we should know about you? Y \_\_\_ N \_\_\_

Explain: \_\_\_\_\_

### Address

You can complete the referral form and deliver or mail it to:

**The Cedars**

40 Begbie Street

New Westminster, BC V3M 3L9

**Phone:** 604.526.2522

**Fax:** 604.526.6546