



Residential Recovery House Program The Realistic Success Recovery Society – Residential Program Referral Package Overview

Please note, submission of a completed referral package does not constitute acceptance for admission. **Acceptance into the Program and an assigned admission date will be provided to you. This will occur after all five forms are reviewed by the Society and the prospective client has completed an over the phone intake with the Executive Director (778-885-4369).** The referral package includes the following forms:

1. **REFERRAL FORMS:** (p. 2-6) to be completed by Referral Agent.
2. **RELEASE FORM:** (p.7) to be completed by Client.
3. **MEDICAL FORMS:** (p. 9-10) to be completed by Family Physician.
4. **CLIENT SELF-ASSESSMENT:** (p. 11-12) to be completed by Client.

We would like to remind Clients that you are in retreat for the first 14 days during which there are no visitors or phone contact except for confirmation of arrival and emergencies. (See Client Information Package.)

PLEASE ENSURE THAT YOU REVIEW THE **CLIENT INFORMATION PACKAGE** PRIOR TO ADMISSION, INCLUDING THE RULES & GUIDELINES AND INFORMATION FOR FRIENDS & FAMILY.

CRITERIA:

1. Men 19 years of age or over (or who are emancipated minors) from within the province of BC.
2. Meets referral criteria for residential treatment: a pattern of chronic misuse of substances and an assessment indicating intensive residential treatment is the appropriate treatment setting.
3. Is not currently prescribed Methadone.
4. Medically able to participate in the program, i.e. does not have current physical health problems that would prevent participation in group sessions i.e. acute back or tooth pain.
5. Emotionally able to participate in group therapy.
6. Able to understand and verbally communicate in English.
7. Committed to making a change in his life.

REFERRAL FORM – To be completed by Referral Agent

Referring Agent: _____ E-Mail: _____
Agency/Company Name: _____
Agency/Company Address: _____

Phone: _____ Fax: _____
Date: _____

Residential Recovery Home Program

CLIENT INFORMATION

Client name: _____

Address: _____
Street City Postal Code

Phone: _____ Age: _____ Date of birth: _____

SIN #: _____ Health #: _____

Marital status: _____ No. of children: _____

Age of child: _____ Age of child: _____ Age of child: _____ Age of child: _____

Number of children living with the client: _____ Other dependants: _____

1. Is this a readmission to Realistic Success ? No Yes

2. Prior admission date: _____

3. Do you have pending charges? No Yes

Court involvement or probation? No Yes

Bail commitments? No Yes

Please describe: _____

ALCOHOL AND DRUG USE SUMMARY

1.

2.

3.

4.

5.

6.

4. Does client have any special needs (i.e. literacy, disability)? No Yes

Please describe:

5. Primary substance(s) abused:

6. Other addictions of concern (e.g. gambling, sex, shopping):

7. Cigarette smoker? No Yes How many per day? _____

8. Is client referred for treatment by the Justice system (condition of bail, etc.)?

No Yes

Please describe: _____

9. Is client presently using methadone? No Yes

Please describe: _____

HEALTH ASSESSMENT

Detox Required: No Yes

Please list physical conditions (e.g. migraines, dental, chronic back pain, withdrawal symptoms) that may:

Impact client's participation in treatment

Require medical follow-up during treatment

Has client have been subjected to physical or sexual abuse? Please detail any prior trauma counselling:

RESIDENTIAL TREATMENT READINESS

Are any of the following **health risk behaviours** currently present? (Within the last 6 months.)

	No	Yes	How Often	Last Time	How Managing
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>			
Self-Inflicted Violence e.g. cutting	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization for Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>			

Please describe:

Any additional dual disorder concerns?

What individual or therapeutic group counselling has the client experienced in the past six months?

What recent involvement has the client had with self-support groups, i.e. 16 Step, N.A., A.A., etc.?

Approximately how many contacts have you had with the client in the past six months? _____

What do you see as this client's particular strengths and abilities?

What challenges might he experience in a residential recovery home setting??

What are your overall treatment goals for this client?

Are you planning on providing follow-up counselling for this client post-Realistic Success Recovery Society? Yes No

Comments? _____

Thank you.

PAYMENT FOR RECOVERY PROGRAM

PAYMENT FOR YOUR RECOVERY PROGRAM: Fee is payable to The Realistic Success Recovery Society by money order, cash or cheque upon being accepted into one of our houses.

No refunds are paid to you if you relapse, leave without written notice; or are evicted with cause.

How are you paying for your recovery? _____

NAME: _____

Please tell us where your money is coming from.

SOURCE		AMOUNT	DOCUMENTS REQUIRED
Ministry of Housing and Social Services	<input type="checkbox"/>	\$ _____ Basic Benefits <input type="checkbox"/> Disability Benefits <input type="checkbox"/>	_____ Office _____ Phone # Fax #
Medical Services Branch Health Canada	<input type="checkbox"/>	\$ _____	Certification of Subsidization for registered First Nations Client
Employee Assistance Program	<input type="checkbox"/>	\$ _____	Letter from employer/agency showing amount paid on behalf of client
Client	<input type="checkbox"/>	\$ _____	Certified Cheque or money order
Other	<input type="checkbox"/>	\$ _____	Source of funds: _____



The Realistic Success Recovery Society

TO BE SIGNED BY CLIENT:

For the purposes of confirming payment, I hereby give permission to The Realistic Success Recovery Society to contact:

- Ministry of Housing and Social Development Benefits (If MHSD funding is to be used, please complete page 6)
- Employee Assistance Program
- Other (Specify): _____

Client Signature: _____

Client Name: _____

Date: _____



Dear Doctor:

Your patient has applied for admission to The Realistic Success Recovery Society. The Realistic Success Recovery Society provides a recovery program for addictions based on 0 tolerance for mood altering substances. The recovery homes operated by The Realistic Success Recovery Society are non-medical facilities; so all clients must be medically stabilized prior to admission. Clients will be taken to see a Physician when necessary. During treatment emergency care is available on a 24-hour basis through the Surrey Memorial Hospital emergency department.

It is expected that clients admitted to Realistic Success Recovery Society be able to participate mentally, emotionally and physically in the intensive program without the need for ongoing medical care. We would appreciate it if you could fill in the accompanying medical form

We are passionate in our desired to help addicts. Potentially addictive medications such as opiates, benzodiazepines and barbiturates are not allowed. Please ensure that any medical condition such as Chronic Pain Syndrome and migraines are well controlled without the need of the above medications. **If special circumstances exist, please forward information on the medication in question.**

Other inappropriate referrals to Realistic Success Recovery Society include men with the following disorders:

- Paranoid and other fixed delusions;
- Auditory, visual, or kinesthetic hallucinations;
- Suicidal ideation; and
- Other thought disturbances which seem out of the person's control and not accessible to efforts to change.

Previous experience indicates these conditions impair the ability of the client to form functional relationships with other clients and staff and usually lead to failure to complete the program.

If in doubt, please feel free to contact me for further discussion about your patient's individual needs. If you become aware of any reason why your patient would not be appropriate for the program, please inform us as soon as possible.

Gary Robinson
Executive Director
778-885-4369



**The Realistic Success Recovery Society
Residential Program**

PRE-ADMISSION MEDICAL FORM

TO BE FILLED IN BY THE EXAMINING PHYSICIAN AND RETURNED TO THE REALISTIC SUCCESS RECOVERY SOCIETY REFERRAL AGENT.

CLIENT MUST SIGN CONSENT ON BOTTOM OF PAGE 10.

PLEASE PRINT OR STAMP

Date: _____

Examining Physician: _____

Physician Address: _____
STREET CITY POSTAL CODE

Physician Phone #: _____ Physician Fax #: _____

Physician E-Mail: _____

Client Name: _____

Client Health Number: _____

Client has had a TB Test within the last 6 months.

Type of Test: _____ Result _____ Date of test: _____

Client is medically and physically able to participate in an intensive group-counselling program.

Please note if the client has used substances in the following categories, and indicate the date of last use.

	Name of Drug	Date of last use
Alcohol	_____	_____
Barbiturates	_____	_____
Cannabis	_____	_____
Cocaine	_____	_____
Crack Cocaine	_____	_____
Meth Amphetamine	_____	_____
Amphetamines	_____	_____
Heroin	_____	_____
Tranquilizers	_____	_____
Benzodiazepines	_____	_____
Sleeping Medications	_____	_____
Other	_____	_____

Current medical problems (**diagnosis & medications**): _____

Current and past psychiatric problems (**diagnosis and medications**): _____

Past hospitalizations/recent operations Date _____

Allergies: _____

Does the client carry an Ana-kit? Yes No

Signature of examining physician: _____ Date: _____

Client signature: _____ Date: _____



The Realistic Success Recovery Society

CLIENT SELF- ASSESSMENT FORM

Client Name: _____ **Date:** _____
Please Print

To assist you in your treatment at The Realistic Success Recovery Society, please complete the following as honestly and thoughtfully as you can. This form is to be returned to us along with your financial and medical forms.

1. My biggest block to staying clean and sober right now is:

2. My personal strengths right now are:

3. My fears about recovery are:

4. Situations in my life that might interfere with treatment are:

5. The changes I would like to see in myself by the end of the recovery program are:

➤ In the area of substance abuse: _____

➤ In the area of physical health: _____

➤ In the area of emotional health: _____

➤ In the area of inner wisdom/spiritual growth: _____

➤ In the area of social/relationship growth _____

Our program of recovery has no time limitations. We encourage residents to remain in the program for at least 12 months; in our experience this length of stay dramatically increases a resident's chance of success for a clean and sober life. We have several residents who have made a home for themselves at one of the Trilogy Houses, being a resident for more than two years.

As a place of recovery we endeavour to provide every client with the opportunity to engage in a process of discovery, a process that involves looking at ones self carefully and deciding what needs to change. Each person will also have some understanding about what work remains to be done, as they continue in the journey of living a clean and sober life after leaving the recovery program.