

Kelowna's
Gospel Mission

Harmony House Referral Form

Kelowna Gospel Mission Society

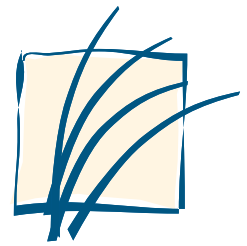
A Place Where One Can Find Hope, Healing... and the love of Christ.

Tel/Fax: (250) 763-6544

| REFERRAL INFORMATION | | |
|----------------------------------|----------------------------|------------------|
| Referring Agent | | Referring Agency |
| Phone Number | Fax Number | E-mail |
| Reason for Referral | | |
| RESIDENT INFORMATION | | |
| Name | | DOB |
| Address | | Age |
| Phone No. | | Marital Status |
| SIN | | Care Card Number |
| Family/Next of Kin Contact | | Phone No. |
| Number of Children | Ages and Names of Children | |
| Special Interests/Talents/Skills | | |
| EMERGENCY CONTACT INFORMATION | | |
| Name | | Address |
| Phone No. | Alternate Phone No. | Relationship |
| Alcohol and Drug Counsellor | | Phone No. |

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Harmony House Referral Form (cont.)

| | | | |
|---|-------------------|------------------|----------------------|
| Case Manager | Phone No. | | |
| Family Physician | Phone No. | | |
| Psychologist/Psychiatrist | Phone No. | | |
| Other Professional/Community Supports | Phone No. | | |
| ALCOHOL AND DRUG USE SUMMARY | | | |
| Substances Used (ü) | Within Last Month | Within Last Year | Within Your Lifetime |
| Alcohol | | | |
| Marijuana | | | |
| Cocaine/Crack | | | |
| Heroin | | | |
| Ecstasy (MDMA) | | | |
| GHB | | | |
| Crystal Meth | | | |
| Psilocybin (mushrooms) | | | |
| LSD (acid) | | | |
| Other Addictions of Concern (for example, gambling, shopping, sex, gaming) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain; | | | |
| Prescription/Other drug Misuse? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain; | Drug of Choice? | | |
| Residential Treatment Attended treatment <input type="checkbox"/> Yes <input type="checkbox"/> No - if yes, completed treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Location & dates: | | | |

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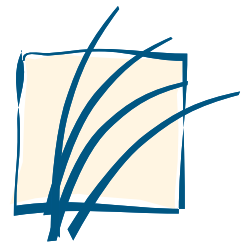
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Harmony House Referral Form (cont.)

| | | |
|--|--------|---------------------------|
| Methadone Maintenance Program <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If yes, provide start date and dosage | | Prescribing Physician |
| Psychiatric Diagnosis/History of Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain;</i> | | |
| Have you ever been hospitalized for a psychiatric illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide date and details;</i> | | |
| Suicidal Thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain;</i> | | |
| History of Self-Inflicted Harm? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain;</i> | | |
| MEDICAL INFORMATION | | |
| Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe;</i> | | |
| Health Problems <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details;</i> | | |
| Tobacco Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No | | Number per day |
| Current Medications | | |
| Medication | Dosage | Purpose/reason prescribed |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

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Harmony House Referral Form (cont.)

| |
|--|
| History of Aggressive/Violent Behaviour? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain;</i> |
| History of Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide details (substance related);</i> |
| History of Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No History of Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No History of Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No |
| LEGAL INFORMATION |
| Currently on Probation/Parole? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details regarding conditions of your probation/parole (no contact order, curfew, counselling, etc.)</i> |
| PERSONAL INFORMATION |
| Level of education completed Elementary (K – 6) Middle (7-9) Senior (10-12) Post Secondary |
| Does client have any special needs (literacy, nutritional, disability, medical, spiritual, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please describe;</i> |
| Applicant signature: |
| Date: |
| Referral Agent signature: |
| Date: |
| <i>Office use only:</i> |
| Interview <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date/time: |

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