FOURCAST

PADDOCK WOOD
Bed-Based Addiction Services

Clear Form

Paddock Wood Bed-Based Treatment Referral Package

Service User Information		
First Name:	Last Name:	
DOB: (dd/mm/yyyy)	Gender: Sex assigned at birth:	Health Card #:
Address:	Email:	
Phone Number: Permission to: ☐ Call ☐ Leave voicemail ☐ Text ☐ Identify as Fourcast staff		
Languages spoken:	Preferred service language:	

Referral Source (leave blank for self-referral)	
Name:	Organization/Agency:
Contact Information (phone, fax, email):	
Date of referral:	

Goals
What are your goals for attending treatment?
What do you currently do to take care of yourself/practice self-care?
Is there anything that might prevent you from actively participating in treatment?

Post-Treatment Planning

What are your hopes for post-treatment services? Do you plan to maintain connection to your referring party? (*if applicable)* What other services are you hoping to be connected to for continuing care?

What are your plans for transportation to and from treatment?

Note, this must be arranged before starting treatment.

Housing Status

Please select your housing status:

I am currently housed and can return to my housing post-discharge.
Type of housing: ☐ Permanent Housing (eg. rent/own) ☐ Transitional Housing

I am currently living in a shelter and can return to my shelter bed post-discharge.
Shelter: ☐ Brock Mission ☐ Cameron House ☐ YES
☐ Wolfe St Modular ☐ Other:

I am currently unhoused and need support with housing.

Physical Health

Do you have a primary care provider?
Yes No

If yes, provide name & contact information:

Do you have specialists involved in your care?
Yes No

If yes, provide details (type of specialist, name(s), & contact information):

Do you require accommodation for your physical health?
Yes No

Is there anything about your physical health that may prevent you from engaging in treatment?
Yes No

If yes, explain:

Do you have any allergies? Yes No
If yes, please list them below:

Allergen	Reaction

Do you require an epi pen? Yes No

Do you have any of the following medical conditions? Write Y or N beside each one:

Condition	Y/N	Details (dates/treatments/hospitalizations)	Family history of same? Y/N
High blood pressure			
Low blood pressure			
Congestive Heart Failure/Heart disease			
Heart Attack		Date of last heart attack: Comments:	
Stroke		Date of last stroke: Comments:	
Pacemaker			
Pulmonary Embolism /Deep Vein Thrombosis			
COPD/Emphysema			
Asthma			
Bronchitis			
Sleep Apnea			
TB			
Seizure disorder		Date of last seizure: Comments:	
Liver problems			
Renal problems			
GI bleed			
Cancer			
HIV			
Hepatitis			
Skin conditions/wounds			
Vision problem			
Hearing loss			
Pregnant/chance of pregnancy			
Previous surgeries			

Do you have any mobility concerns with walking, climbing stairs, bending or frequent movement? *Note: Paddock Wood has multiple stairs and no ramps or elevators* Yes No If yes, explain:	
Do you have any upcoming medical procedures, appointments, or surgeries, in next 3-6 months? Yes No If yes, provide details for date, time, purpose:	Have you been hospitalized for your physical health in the past three months? Yes No If yes, explain:
Do you have any dietary restrictions? Yes No If yes, explain:	Have you ever been diagnosed with a learning disability? Yes No If yes, explain:
Is there anything you would like us to know regarding your sexual orientation and/or your gender identity that would help us in providing you with high quality care? Yes No If yes, explain:	

Current Medications			
Medication Name (E.g. prescription medications, vitamins/over the counter medications, etc.).	Dosage	Route/Timing	Reason for medication

Current Pharmacy: Name Contact information			
Drug Coverage: ☐ Ontario Works ☐ ODSP ☐ Private/Employer Plan ☐ NIHB ☐ None (self-pay)			

Mental Health

Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No
If yes, please explain:

Do you experience any symptoms of mental health conditions? ☐ Yes ☐ No
If yes, please explain:

Have you been hospitalized for mental health in the past 12 months? ☐ Yes ☐ No
If yes, please explain:

Are you currently connected to a psychiatrist? ☐ Yes ☐ No
If yes, provide their name and contact information, and any upcoming appointments:

Are you currently receiving counselling, support or treatment related to your mental, emotional, behavioural, psychological wellness or substance use? ☐ Yes ☐ No
If yes, provide details:

Have you ever received counselling/treatment related to mental, emotional, behavioural, psychological wellness or substance use? Yes No
If yes, where? What worked well? What didn't work well?

Have you ever seen or heard things that no one else could see or hear? ☐ Yes ☐ No If yes, explain:	Have you ever felt as though people were against you or trying to harm you? ☐ Yes ☐ No If yes, explain:
Do you currently have access to weapons? ☐ Yes ☐ No If yes, explain:	Do you have a history of setting fires? ☐ Yes ☐ No If yes, explain:
Have you ever purposely damaged or destroyed property that wasn't yours?	Do you have any concerns about your ability to get along with others?

☐ Yes ☐ No If yes, explain:	☐ Yes ☐ No If yes, explain:

Are you **currently** experiencing thoughts of suicide, self-harm, or harm to someone else?
☐ Yes ☐ No
If yes, what do the thoughts say? How often? How long do they usually last?

Do you currently have a plan for suicide, self-harm or harm to someone else? ☐ Yes ☐ No

Do you intend to carry out that plan? ☐ Yes ☐ No

If yes to either of the above, please explain:

Have you ever had thoughts about suicide, self-harm or harm to someone else? ☐ Yes ☐ No

Have you ever had a plan to end your life? ☐ Yes ☐ No

Have you ever tried to end your life? ☐ Yes ☐ No

If yes to any of the above, please explain the circumstances (how long ago, context):

Have you behaved violently or aggressively towards others recently? ☐ Yes ☐ No

Have you ever behaved violently or aggressively towards others? ☐ Yes ☐ No

If yes to either of the above, please explain the circumstances (how long ago, context):

Substance Use						
	Alcohol	Cannabis	Opiates	Stimulants	Nicotine/ Tobacco	Other
Substances used in the past year	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Frequency of use in the past 30 days	☐ Daily ☐ Weekly ☐ Occasional	☐ Daily ☐ Weekly ☐ Occasional	☐ Daily ☐ Weekly ☐ Occasional	☐ Daily ☐ Weekly ☐ Occasional	☐ Daily ☐ Weekly ☐ Occasional	☐ Daily ☐ Weekly ☐ Occasional
Quantity/ Amount used						
Method of use:	☐ Orally ☐ Snorting ☐ Smoking ☐ Injecting	☐ Orally ☐ Snorting ☐ Smoking ☐ Injecting	☐ Orally ☐ Snorting ☐ Smoking ☐ Injecting	☐ Orally ☐ Snorting ☐ Smoking ☐ Injecting	☐ Orally ☐ Snorting ☐ Smoking ☐ Injecting	☐ Orally ☐ Snorting ☐ Smoking ☐ Injecting
Date and Quantity of last use:						
Approximate length of use						
Withdrawal symptoms experienced	☐ Headache ☐ Nausea ☐ Restless ☐ Cravings/ Urges ☐ Irritability/ Agitation ☐ Shaking/ Tremors ☐ Other:	☐ Headache ☐ Nausea ☐ Restless ☐ Cravings/ Urges ☐ Irritability/ Agitation ☐ Shaking/ Tremors ☐ Other:	☐ Headache ☐ Nausea ☐ Restless ☐ Cravings/ Urges ☐ Irritability/ Agitation ☐ Shaking/ Tremors ☐ Other:	☐ Headache ☐ Nausea ☐ Restless ☐ Cravings/ Urges ☐ Irritability/ Agitation ☐ Shaking/ Tremors ☐ Other:	☐ Headache ☐ Nausea ☐ Restless ☐ Cravings/ Urges ☐ Irritability/ Agitation ☐ Shaking/ Tremors ☐ Other:	☐ Headache ☐ Nausea ☐ Restless ☐ Cravings/ Urges ☐ Irritability/ Agitation ☐ Shaking/ Tremors ☐ Other:

Confidence:



1 (not at all) 10 (very)

How confident do you feel in your ability to make changes to your substance use and why?

Have you ever been asked to leave treatment before completing?

☐ Yes ☐ No

If yes, please explain:

Gambling Information

Do you currently gamble? ☐ Yes ☐ No	Do you have a history of gambling? ☐ Yes ☐ No

If yes to either of the above, please fill out the following chart. If no to both, skip to Legal section.

Type of activity	Have you played within: the last 12 months?	Have you played within: your lifetime?	Method	Frequency of play	Age first played	Date last played (approx.)
Slot machines	□ Yes □ No	□ Yes □ No	□ Virtual/cell phone □ In person □ Both	□ Daily □ Weekly □ Occasional		
Gaming machines other than slots	□ Yes □ No	□ Yes □ No	□ Virtual/cell phone □ In person □ Both	□ Daily □ Weekly □ Occasional		
Card / table games	□ Yes □ No	□ Yes □ No	□ Virtual/cell phone □ In person □ Both	□ Daily □ Weekly □ Occasional		
Horse races	□ Yes □ No	□ Yes □ No	□ Virtual/cell phone □ In person □ Both	□ Daily □ Weekly □ Occasional		
Lottery / scratch tickets	□ Yes □ No	□ Yes □ No	□ Virtual/cell phone □ In person □ Both	□ Daily □ Weekly □ Occasional		
Internet gambling	□ Yes □ No	□ Yes □ No	□ Virtual/cell phone □ In person □ Both	□ Daily □ Weekly □ Occasional		
Betting	□ Yes □ No	□ Yes □ No	□ Virtual/cell phone □ In person □ Both	□ Daily □ Weekly □ Occasional		

How has gambling affected your life (relationships, work/school, finances, health, hobbies, etc.)?
Do you want to make changes to your gambling? Explain:

Legal

Do you have any current legal concerns? ☐ Yes ☐ No
If yes, please explain the charges, dates, any upcoming court dates, and any other information:

Do you have any previous legal concerns? ☐ Yes ☐ No
If yes, please list your past charges including dates.

Relationships and Social Supports

Do you have children? ☐ Yes ☐ No If yes, please list their name(s), age(s):	Is child welfare involved in their care (ex., CAS, DBCFS)? ☐ Yes ☐ No If yes, please describe (agency, worker, plans):

If your child(ren) is(are) under 16, who has legal custody?	Do you feel as though your family and friends are: Supportive of you? ☐ Yes ☐ No Of your treatment goals? ☐ Yes ☐ No Who are your main supporters? (please list)
Who will care for your child(ren) while you are attending treatment?	

Do you have pets? ☐ Yes ☐ No
If yes, what is your plan for pet care while you are attending treatment?

Other Important Information

Medication Requirement Notice:
Please note that all medications, including prescription medications, over-the-counter medications (e.g., Tylenol, Advil, antihistamines), vitamins, supplements, melatonin, etc., require a valid prescription while you are in the program. To help avoid delays with your admission, we encourage you to connect with your Primary Care Provider (or other prescribing healthcare provider) and your current pharmacy as soon as possible to ensure all required prescriptions are up to date and transferred to: George Street Pharmacy. All medications administered during your stay are dispensed through George Street Pharmacy using a blister-pack system. To help ensure your medications are available upon admission, please contact the pharmacy before your admission date to arrange the transfer of your prescriptions. Because your medications will be supplied through George Street Pharmacy, please do not bring medications with you to the program unless you have been specifically instructed to do so by program staff. Our medication storage space is limited, and we may not be able to accept or store medications brought from home.

☐ I have read and understand the medication requirements for the program

☐ I understand that I am responsible for arranging the transfer of my prescriptions George Street Pharmacy prior to my admission date.

Bed Bug Protocol: Staff take precautions to ensure that Paddock Wood is monitored for bed bugs. Our protocol includes heat treating all personal items for prevention and monitoring purposes. Personal items that cannot withstand heat treatment will be secured in sealed bags for 24 hours or longer for prevention and monitoring. Following heat treatment, all clothing items must be laundered as part of the bed bug prevention process. Service users will be supported in accessing on-site laundry facilities as required.

☐ I understand and consent to the bed bug protocols outlined above.

Safety Checks: Staff will periodically check service users' person (turn out all pockets, un-tuck shirt, lift pant legs, remove shoes and hat, and empty out any knapsacks or bags), belongings, and the facility as a whole. Checks are conducted to ensure the safety of all service users and staff. If any items of concern are found, they will be stored and/or disposed of in accordance with organizational protocols and the law. If a check is refused, a service user may be asked to leave treatment as safety is a top priority.

☐ I understand and consent to safety checks.

Urine Drug Screen and Breathalyzer: For the safety of all service users and staff, urinalysis and breathalyzer screening will occur on admission and at the discretion of staff throughout treatment.

☐ I understand and consent to urinalysis and breathalyzer screening.

Consent to Share Information:
Please complete the attached consent form (see next page) and include:

- ✓ Your referral party (if applicable)
- ✓ Your prescribing Physician (if applicable)
- ✓ Any other providers who may be supporting you throughout your treatment.

Please note that we request for your consent to exchange information with George Street Pharmacy (our partnering pharmacy), Peterborough Regional Health Centre (PRHC) in the event of transfer to emergency department and/or care coordination and Connecting Ontario (eHealth Ontario's secure electronic health record system that allows authorized healthcare providers to securely access your health information such as lab results, diagnostic imaging reports, medications, and hospital visits) to support your referral and admission process. Please contact us if you have any questions.

Consent and Declaration	
☐ **I confirm that the information provided is as complete and accurate as possible.**	
Full Name:	Date:

Once you have completed this form, please attach it to your online referral, and include copies of any recent assessment tools (GAIN Q3/Q4 MI, ADAT) so we can review and then connect with you to discuss next steps.

Note, if you do not have any recent assessment tools, we will be happy to complete them with you.

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Four Counties Addiction Services Team Inc.
Multi-Agency Consent for Release and Exchange of Information

I, _____ _____
Full Name Date of Birth

of _____
Address

authorize Four Counties Addiction Services Team to

☐ **Release to** and/or ☐ **Request from** the following agencies/individuals:

Agency/Individual Name	**Consent Given**
Connecting Ontario	
George Street Pharmacy	
PRHC (in event of transport to ED or care coordination)	
Primary Care Provider's Name: Contact Information	
Care Provider's Name: Contact Information:	

The following information:

- Psychiatric and/or psychological diagnosis/assessment
- Mental health treatment I have received
- Criminal record and/or
- Pertinent medical information that impacts on my functioning, mental health or ability to attend bed-based treatment.

I understand that identified service providers who work with me or on my behalf will consult with me and with each other about my needs. I understand the identified service providers will share information about me but only as necessary for them to plan, provide and evaluate the service that I have requested and/or received. I understand that I can refuse to sign this consent form or withdraw my consent at a later date.

☐ **I understand that this consent is valid for 12 months from the date below:**

_____ _____
Client or Substitute Decision Maker* Date

_____ _____
Witness Date

*A substitute decision maker is a person authorized under PHIPA to consent, on behalf of the individual to disclose personal information about the individual.

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CONFIDENTIALITY STATEMENT AND SHARING YOUR INFORMATION

Confidentiality is very important at Four Counties Addiction Services Team (Fourcast).

When attending services at Fourcast, all information you share is confidential and we will only share your information with your written consent.

However, there are situations when we are required by law to share information without your consent. They are:

- **Situations where a child is considered at risk**. We are legally required to report any child protection concerns to the Children's Aid Society.
- If there is a risk that you are **intending to harm yourself or someone else**.
- **A subpoena from the courts** requiring Fourcast to share information about your involvement with us.
- **You arrive at your appointment impaired and insist on driving**. Fourcast staff are legally required to report to the police if you refuse an alternative arrangement.
- **A medical emergency**.

Keeping Electronic Health Records

The Ministry of Health funds our programs and requires us to create an electronic record of your involvement. Here is how it works:

- We enter information about you and the services we have provided in a secure web-based software program called EMHware or in any systems or software that may replace EMHware in the future.
- All electronic files are securely held using encryption technology and are monitored for privacy protection.

☐ **I acknowledge that I have been informed of Fourcast's Confidentiality Statement and consent to sharing the information in this referral package with Fourcast.**

Client Name	Date
Witness Name	Date

We respect your privacy, your personal health information, and follow all privacy laws. Please refer to our Privacy Brochure and speak to your counsellor if you have questions or concerns.

Please note submitting incomplete forms may delay the referral process until all information is collected

Save Referral Package