Stonehenge
Therapeutic Community

Support. Hope. Thrive.

ADDICTION SUPPORT COORDINATION

REFERRAL FORM

EXTERNAL – PROTECTED B

PROTECTED B WHEN COMPLETE

Send completed referrals to ASC FAX #: 1-833-392-1157

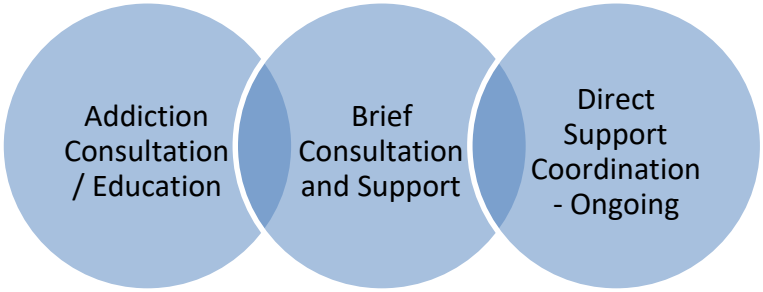
Program Description:

The Addiction Support Coordination (ASC) Program strives to improve the health and wellbeing of individuals who are members of a ***specialized population*** living with complex addiction issues, and to enhance the capacity of the health care system to respond effectively to their unique needs.

This program focuses on providing services to individuals, and the health services working with them, who have such complex needs that they:

- Lack appropriate service options within the existing continuum of care
- Are waiting for appropriate service options without sufficient addiction support resulting in cyclical crisis and emergency department usage
- Consistently utilize / require emergency services including police, emergency department, withdrawal management, etc.
- Are not receiving sufficiently intensive service to be supported effectively in the community

Continuum of Services Provided in Addiction Support Coordination



Addiction Consultation / Education

- Providing professional, addiction-focused consultation to service providers engaged with the client
- Utilizing harm reduction principles – including abstinence as appropriate to client need
- Delivering addiction education tailored to the needs of health service providers
- The individual does not become a client of the ASC program

Brief Consultation and Support

- Providing time-limited wrap-around support for the client as required
- Providing addiction specific assessment and treatment planning alongside the client and another provider
- Involves short-term, direct contact with client and other providers to address addiction-related needs

Direct Support Coordination – Ongoing

- Providing support coordination and addiction counselling services as part of a ***collaborative treatment team***

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Fit for Service Checklist: Prior to completing referral form, please complete checklist below to determine fit for service for Addiction Support Coordination (ASC)

PART ONE - FIT FOR SERVICE: All below must apply:

- ❑ Chronic/acute substance use. (May include prescription medication)
- ❑ Is agreeable to addiction supports that follow the harm reduction continuum
- ❑ Has other service providers involved in their care

PART TWO – SPECIALIZED POPULATIONS: The individual must also be part of **ONE OR MORE** of the following specialized populations (please describe):

- ❑ Acquired Brain Injury: _____
- ❑ Developmental Disability or Dual Diagnosis (Developmental Disability & Mental Health Diagnosis): _____
- ❑ Geriatric (65 or older) or presenting with geriatric issues due to substance use: _____
- ❑ Complex Concurrent Mental Health: _____

If the individual does not meet the above criteria, they are not eligible for Addiction Support Coordination. Do not proceed with referral – connect with HERE 24/7 (1-844-437-3247).

If individual meets above criteria, please complete all referral sections thoroughly.

REFERRAL SOURCE INFORMATION			
Referral Source		**Referral Contact Phone Number**	
Date of Referral		**Referral Contact Email Address**	
Reason for Referral			

ACTIVE ONGOING SERVICE PROVIDERS	
Service Provider (Name/Role/Organization)	**Contact Information**

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CLIENT INFORMATION			
Client Name		**Phone Number**	
Address		**Date of Birth**	

Where is the client currently living?

❑ House/Apartment – Owned ❑ House/Apartment – Rented ❑ Family Home	❑ Seniors Residence / Long-term Care Facility ❑ Supportive Housing ❑ Shelter / No Fixed Address

What is the client's income source?

❑ Employment ❑ Family / Friends ❑ ODSP – Ontario Disability Support Program	❑ OW – Ontario Works ❑ CPP - Canadian Pension Plan ❑ Other: _____

What is the client's employment status?

❑ Employment – Full Time ❑ Employment – Part Time ❑ Volunteering ❑ Unemployed	❑ Student / Retraining ❑ Retired ❑ Unknown

SUBSTANCE USE

How does the client see themselves benefitting from ASC?	

Which substances has client used in the past 6 months? (check all that apply)

❑ Alcohol ❑ Benzodiazepines ❑ Cannabis ❑ Cocaine/Crack ❑ Ecstasy ❑ Inhalants	❑ Hallucinogens ❑ Opiates ❑ Methamphetamines ❑ Prescription Steroids ❑ Other: _____

Substance	Pattern / Frequency	Amount	Last Use	Method of Use

Has a GAIN Assessment been completed in the last 4 months?	❑ No ❑ Yes (If yes, please attach it to this referral)
Has the client ever participated in an Addiction Treatment program?	❑ No ❑ Yes (if yes, please complete the following)

Program Name	When Did They Attend	Completed?
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

PHYSICAL AND MENTAL HEALTH	
Does the client have any physical health concerns?	❑ No ❑ Yes (describe & attach medication list): _____ _____
Does the client experience any mental health concerns/diagnoses?	❑ No ❑ Yes (describe): _____ _____
Has the client experienced thoughts of self-harm and/or suicide?	**Currently:** ❑ No ❑ Yes (describe): _____

	In the Past: ❑ No ❑ Yes (describe): _____

HOSPITALIZATIONS	
Has the client attended the emergency department in the last 12 months?	❑ No ❑ Yes (# of times & reason(s)): _____ _____
Has the client been admitted to hospital in the last 12 months?	❑ No ❑ Yes (# of times & reason(s)): _____ _____
LEGAL INFORMATION	
Is the client currently on probation or parole?	❑ Yes - Probation ❑ Yes - Parole ❑ No
If yes, describe: (conviction(s), length/conditions, outstanding charges/bench warrants, upcoming court dates)	
ADDITIONAL INFORMATION	
Is there anything else we should know?	

If you have questions, please call our ASC Toll-Free line: 1-833-272-0003 / 1-833-ASC-0003

Please attach any/all supporting documents:

- GAIN Assessments / Psychological Assessments
- Medication Lists
- Any additional supporting Hospital/Medical Records

Please send completed referrals and all supporting documents to ASC FAX #: 1-833-392-1157

Addressed: – Attn: Addiction Support Coordination (with region – Cambridge or Guelph or Kitchener)