Vancouver Coastal Health
Promoting wellness. Ensuring care.

# ADDITIONAL FORMS for CAIT INTAKE REFERRALs

## 1. CONSENT FOR RELEASE OF INFORMATION

Please indicate below your consent for STLR or Treatment Facility and CAIT staff to share your personal information with the following individuals:

| Name | INVOLVEMENT (e.g lawyer, PO, Probation) | TELEPHONE # (include extensions) | Limitations to the information you consent to share |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

I, ______________________ (full name) consent to the release of information as specified above

**Client Signature**: DATE:______________________
DD/MM/YYYY

## PHARMANET CONSENT

The Province of British Columbia has established the provincial computerized pharmacy network and database known as "PharmaNet" pursuant to Section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363.

**I** ______________________ **PHN:**______________________
**PRINT NAME**

Authorize access to my personal health information contained within Pharmanet by medical practitioners, pharmacists, and other authorized persons for the purpose of providing therapeutic treatment or care to me in ______________________ [Facility Name, Please Print]

**Client signature:** **Date:**

**Witness Signature:**

**Print Witness Name & Relationship:**

All Forms to be completed and sent with all CAIT intake referrals: Fax forms to **604 681-1894**

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## 2. EARLY EXIT TRANSITION PLAN

**CLIENTS NAME:** **Referred BY:**

Should I leave the selected STLR or Treatment Centre prior to program completion, **I agree to utilize the support of the STLR or Treatment Facility staff for resource information, and safe exit/transition planning and**:

☐ Return to my home or the home of the individual named below for immediate shelter and transition Support:

and/or

☐ Contact the agency/worker named below for immediate shelter and transition support.

**EARLY EXIT CONTACTS:**

1) Name ________________________________ Relationship ______________________
   Home #: _____________________________ Cell #: ___________________________
   Is this person aware of this plan? Yes ☐ No ☐

2) Name _______________________________ Relationship ______________________
   Home #: _____________________________ Cell #: ___________________________
   Is this person aware of this plan? Yes ☐ No ☐

3) Organization/Agency Name: ____________________ Contact/Workers Name __________________
   Phone #: ___________________________________ Cell #:______________________

CLIENT SIGNATURE______________________________ DATE:____________________________
DD/MM/YYYY

**(Details of your Early Exit Transition Plan):**

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# 3. SDSI FUNDING VERIFICATION

***Must be processed by SDSI & sent back within the same day***

**Referring Agent:** Please complete and return to CAIT, Fax No. 604-681-1894

**Ministry Agent:** Please complete and return to CAIT, Fax No. 604-681-1894

| ***CLIENT NAME:*** | | **DATE of Completion:** | DD | / | MM | / | YYYY |
|---|---|---|---|---|---|---|---|
| ***S.I.N:*** | | **D.O.B.** | DD | / | MM | / | YYYY |

This person has been referred for admission to: Name of residential addictions program.

Prior to admission, we require confirmation that the client's per diem costs (less any non-exempt income) will be paid by SDSI while in receipt of, and eligible for, income assistance. Once the client has been admitted the facility will send an admission report.

| **Income from Other Sources** | **$** | | **Source** | |
|---|---|---|---|---|
| **Income from Other Sources** | **$** | | **Source** | |

| ***Client Authorization*** | I, ……………………………………., authorize the Ministry of Social Development & Social Innovation to confirm my eligibility for funding, and to release any related information to the staff of Vancouver Coastal Health CAIT program and the above named residential/support recovery addictions program.<br><br>________________________________ **Date:**_______________<br>Client Signature DD/MM/YYYY |
|---|---|

**Ministry of Social Development & Social Innovation -** *COMPLETE & SEND BACK THE SAME DAY*

| | |
|---|---|
| ☐ Client has an open and active file<br>☐ Client eligibility yet to be determined<br>☐ Client file has been closed<br>☐ Client is eligible for funding as follows: | ***Comments:*** |

| | | | | | |
|---|---|---|---|---|---|
| | SDSI will pay Client's monthly per diem as per current eligibility less any non-exempt income from other sources as follows: | | | | |
| | Client Contribution: | (non-exempt income) | $ | | |
| | Non-exempt income from | | | | |
| | **Maximum Amount Payable by SDSI Per Month** | | $ | | |

| | | |
|---|---|---|
| **SDSI Contact Name:** | | *Place Office Stamp Here* |
| **Telephone contact:** | | |
| **Date:** | | |

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