THE INSTITUTE FOR CULTURALLY RESTORATIVE PRACTICES
1455 Idylwild Dr. P.O. Box 66
Fort Frances, ON P9A 2N9
Phone: 807-274-2978
Fax: 807-274-7207

Referral Package

(email referral to: estelle.simard@shaw.ca)

PERSONAL INFORMATION

Name:			Date of Birth:
Band Number:		Band Name:	
No. of Children	Ages of Children:		Telephone:
Family Members:			
Mailing Address:	Street: Town & Province: Postal Code:	On-Reserve ☐	Off-Reserve ☐

PROFESSIONAL CONTACTS

Referral Worker Information:		
Name:		Agency:
Phone:	Fax:	Email:
Date of Referral:		

MEDICAL HISTORY

Doctors Name:	Telephone:
Last medical exam (approx.):	
Any professional medical concerns/health problems?	

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Current medication: (name of doctor/psychiatrist who prescribed the medication/report will be required.)	
Current Health Concerns: Yes ☐ ☐ No	Explain (if yes):

HISTORY OF SUBSTANCE USE

Substance	Age of First Use	How many days have you misused in the last 30 days?	Have you ever misused so much that you became ill?	If yes, when?	The date of your last use
Alcohol					
Cannabis (Pot)					
Cocaine					
Hallucinogens					
Heroin					
Amphetamines					
Other					

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Have you used drugs or alcohol before or during school/work? ☐ **Y** ☐ **N**

Have you missed school or work because of substance use? **Y** ☐ **N** ☐

Have you used substances more than 3 days in a row? **Y** ☐ **N** ☐

Have you ever used drugs intravenously? **Y** ☐ **N** ☐

Have you noticed your drug use becoming more frequent? **Y** ☐ **N** ☐

(If yes, explain):

Has anyone told you to cut down or stop using drugs? **Y** ☐ **N** ☐

Have you ever tried to stop using drugs before? **Y** ☐ **N** ☐

If yes, what did you do? **Detox:** **Y** ☐ **N** ☐ **Residential:** **Y** ☐ **N** ☐

Outpatient: **Y** ☐ **N** ☐ **12-Step Programs:** **Y** ☐ **N** ☐

Explain:

How are drugs affecting your life?

PREVIOUS TREATMENT: List all In-patient Treatment received in previous 2 years

Name of Institution	Date Attended	Treatment Completed	After Discharge: Clean & sober / Relapsed
		Y ☐ ☐ N	☐ ☐
		Y ☐ ☐ N	☐ ☐

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PRESENTING PROBLEM

Crisis Situation/Reason for Referral:

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INFORMED CONSENT TO REFERRAL AND PRELIMINARY ASSESSMENT

I, _____,
Name

of _____
Address *City* *Postal Code*

hereby authorize: _____ to make a referral to:
Name of Person or Agency

THE INSTITUTE FOR CULTURALLY RESTORATIVE PRACTICES for:

MYSELF or _____ DOB: _____
Client's Name *Date of Birth*

For the following Assessment and/or Treatment:
(Describe Services Requested)

_____ _____
Signature of Person Referred *Date*

_____ _____
Signature of Legal Guardian or Substitute Decision Maker *Relationship to Person Referred*

_____ _____
Signature of Witness *Date*

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CONSENT TO SHARE INFORMATION

I, _____,
Name

of _____
Address *City* *Postal Code*

Hereby authorize **THE INSTITUTE FOR CULTURALLY RESTORATIVE PRACTICES** to disclose (receive and/or send) the following information:

From/To the following agencies for the purpose of assessment and/or treatment,

In respect of: _____ DOB: _____
Client's Name *Date of Birth*

TO: (List Agency or Organization Below) Please Note: *Client's authorization is required in the form of initial if more than one agency is listed below. If client prefers, individual consent forms can be used for more than one agency/organization.*

_____ _____
Agency/Organization *Client's Signature*

_____ _____
Signature of Person Referred *Date*

_____ _____
Signature of Legal Guardian or Substitute Decision Maker *Relationship to Person Referred*

_____ _____
Signature of Witness *Date*

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INFORMED CONSENT TO TREATMENT/ FOR DATA COLLECTION

I, _____,
Person Referred and/or Substitute Decision Maker/Legal Guardian

of _____
Address *City* *Postal Code*

hereby authorize **THE INSTITUTE FOR CULTURALLY RESTORATIVE PRACTICES** to provide the following assessment and/or treatment services for **MYSELF** or:

_____ DOB: _____
Client's Name Date of Birth

Describe Services Requested:

Or: Do not hereby authorize **THE INSTITUTE FOR CULTURALLY RESTORATIVE PRACTICES** to
a) Systematically collect and store data pertaining to my history and clinical findings in an Electronic data base.
b) Analyze the data for scientific research or quality of care management purposes.

I understand there is no personal risk and my privacy will be maintained in all published and written materials. My medical/clinical records may be available to the investigators in the study but they will not be released to outside parties without my written permission. My participation is voluntary and my decision to participate, not participate or withdraw from the study at a later time will not affect my clinical support.

_____ _____
Signature of Person Referred *Date*

_____ _____
Signature of Legal Guardian or Substitute Decision Maker *Relationship to Person Referred*

_____ _____
Signature of Witness *Date*

- I understand that my informed consent must be obtained before changing or altering the nature of services provided to me.
- I have been advised that all records relating to the provision of services to me are confidential and may not be disclosed without my informed consent. I have also been advised that records may be released without my permission if: (1) I give information that indicated that harm might come to myself or someone else; (2) a child needs protection (report to an appropriate agency); or (3) a court orders the disclosure of records.