One Team Recovery Referral Form

Personal Information

First Name:	Last Name:
Preferred Name if different than above:	
Preferred Pronoun: him/he ☐ her/she ☐ they/them ☐ prefer to self-describe:	
Street Address:	
City:	Postal Code:
Phone: (home) (Cell) (Work)	
Email Address:	
Gender:	Sexual Orientation:
Date of Birth:	
Health Card Number:	
Language Spoken: English ☐ French ☐ Other:	Requires interpreter ☐

Program Specific

Type of Referral:
Self-Referred: ☐
Physician Referred: ☐ Name of referral source:
Community Referral: ☐ Name of referral source:

How did you hear about OTR?
Family Doctor/Nurse Practitioner ☐ Specialist ☐ Friend/Family ☐
WECAS ☐ WTCC ☐ WECHC ☐ ECNPLC ☐ ESFHT ☐ Windsor Pride ☐ HDGH ☐
Website ☐ Facebook ☐
Other Please specify:

OTR program Preference:
OTR Non-specific ☐ OTR LGBTQ+ specific ☐ Aftercare ☐
Friends & Family ☐ *please skip to consent*

Are you currently pregnant? Yes ☐ No ☐ Unsure ☐ N/A ☐

Do you currently have children in your care? Yes ☐ No ☐ N/A ☐

Substance Being Used:

Consent

Patient provided verbal consent to participate in the One Team Recovery Program? ☐ Yes ☐ No

Patient provided verbal consent to ONE Team Recovery program to leave a confidential voicemail? ☐ Yes ☐ No

I consent to the collection, use and disclosure of personal health information but only as is necessary to fulfill the ONE Team Recovery Program & its partners lawful purposes. ☐ Yes ☐ No

Note: all One Team Recovery Program partner organizations are Health Information Custodians and subject to Personal Health Information Protection Act, and include the following: Essex County Nurse Practitioner-Led Clinic, Erie Shores Family Health Team, Windsor Essex Community Health Centre, and the Windsor Family Health Team.

Eligibility

- ☐ Must be 16 years or older
- ☐ Must have an OHIP number
- ☐ Must have housing and a contact number
- ☐ Does not have a primary diagnosis of Schizophrenia
- ☐ Has no active mania or psychosis

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Substance Use History

Substance	Level of Concern			Date of last use?	Route of use
	Low	Medium	High		
Alcohol					
Marijuana/Hash					
Cocaine/Crack					
Opioids (heroin, morphine, Fentanyl, etc.)					
Benzodiazepines (Valium, Ativan, Xanax etc.)					
Club drugs (ecstasy, Ketamine, GHB etc)					
Hallucinogens (mushrooms, LSD, Salvia, etc)					
Amphetamines (crystal meth, Dexedrine, Ritalin, etc)					
Tobacco/E-cigarettes					
Other Drugs (specify)					

Self-Harm/Suicide Ideations

Have you ever attempted suicide or seriously harmed yourself?	**Yes or No**
Are you currently having thoughts of suicide or harming yourself?	**Yes or No**

Personal Commitment

How big of a challenge will it be for you to be drug and alcohol free while you are in this program?

0 1 2 3 4 5 6 7 8 9 10

None Moderate Extreme

Can you commit to not using substance prior or during program?	**Yes or No**
Can you commit to attending all 10 program sessions?	**Yes or No**
Are there any barriers that would prevent you from accessing OTR?	**Yes or No**
Are you choosing to attend this program on your own or is someone suggesting or telling you to attend?	**Yes or No**
Are you currently enrolled/ever in counselling or therapy for your substance abuse?	**Yes or No**
Are you currently enrolled in extended recovery support such as AA, NA, CA, GA, SA etc	**Yes or No**

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Mental Health History

Have you ever received a mental health diagnosis?	**Yes or No**
If yes, diagnosis:	
Are you currently taking any prescribed medication?	**Yes or No**
Medication prescribed:	
Medication prescribed:	
Have you ever been diagnosed with a learning disability or developmental delay?	**Yes or No**
If yes, diagnosis:	
Have you ever been involved with the following organizations? TSC Centre, CMHA, ACT Team, COAST, Community Living	

Behaviour and Treatment History

Do you have any issues expressing your anger?	**Yes or No**
Do you have any history of violence/threats towards others?	**Yes or No**
Are you currently on probation or parole?	**Yes or No**
Are you comfortable are you talking about your personal situations in-front of others?	**Yes or No**
Are you comfortable talking about your feelings?	**Yes or No**
Have you ever attended addiction treatment before?	**Yes or No**
If yes, Where:	
Are you currently on Methadone or Suboxone?	**Yes or No**
Have you ever attended Withdrawal Management? If so, how many times?	**Yes or No**

Treatment Goals & Recovery Environment

What is your goal of attending this program?	**Reduce use or Abstain**
What would you like to learn from this program?	
Who in your family might be open to participating in treatment activities to support you?	
Who are the people in your life right now who are likely to support you to succeed in this program?	
How safe is your living environment right now? other people using/selling substances; psychological/physical security)?	
Would you be interested in Aftercare?	Yes No

FOR OFFICE USE ONLY

Does this client meet the criteria of OTR?	Yes No
If yes, Program start date:	
If no, was an external referral made? Where?	

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