



For Referral: Applicant Inclusionary Criteria

- 19+ year old Women
 - Moderate – Severe Substance Use Disorder
- New Roads welcomes applications for individuals with:**
- Experience with Homelessness
 - Interaction with the Criminal Justice System

WOMEN’S THERAPEUTIC RECOVERY COMMUNITY (WTRC)

94 Talcott Road, View Royal, V9B 6L9

Tel: 250-940-5080 Ext. 4729

Fax: 778-247-2068

E-mail: shelbyt@ourplacesociety.com

Referral date:	Referrer name (self or other):
Referral source (self of other):	Applicant Release date:
Email:	Contact number:
Do you have records to forward with this application upon acceptance into the TRC with ROI complete? Yes No	If yes, please specify:

Applicant information:

Last Name	First Name	Middle Name
Date of Birth (dd/mm/yy)	SIN	PHN
Family Status	Ethnicity	Band Name and #
Source of Income: <input type="checkbox"/> None <input type="checkbox"/> Employment <input type="checkbox"/> INAC Band <input type="checkbox"/> Old Age Security (OAS) <input type="checkbox"/> Income Assistance (IA) <input type="checkbox"/> IA-PPMB (DB1) <input type="checkbox"/> IA-PPMB (DB2) <input type="checkbox"/> Canada Pension Plan (CPP) <input type="checkbox"/> Persons with Disabilities (PWD) <input type="checkbox"/> Other: _____		
What is client’s current housing/living situation?	Do you have any identification?	
Is client facing any immediate safety risks?	Are you currently pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> If yes, when is your due date?	
Allergies:	Dietary needs/nutritional needs?	When were you last tested for TB?
Mental Health issues (schizophrenia, bi-polar, OCD, depression, other)		
Please list any medication and (dosage), including methadone/suboxone		
Doctor:	Dentist:	
Psychiatrist:	Other (i.e., counsellor):	

Is there anything that you need help with immediately? (Appointments, belongings, reminders, probation order, etc.)

Substance Use of Choice:

Date of last use:

Previous and/or current treatment for addiction/mental health? (i.e., group therapy, individual therapy, A.A, N.A etc.) Please include therapist names, locations, and dates if possible.

Barriers/Considerations (i.e. mental health/risks/no prior employment/learning disability):

Why do you think you will be a good fit for New Roads WTRC at this time? (i.e. strengths, values):

What do you hope to achieve through the New Roads process? (i.e. short-term and long-term goals):

I have received, read, and understand the Women's Therapeutic Recovery Community Resident Handbook.

Name: _____ Signature: _____



NEW ROADS WOMEN'S THERAPEUTIC RECOVERY COMMUNITY
CLIENT CONSENT FOR COLLECTION AND DISCLOSURE OF INFORMATION

- I _____ of _____
(first, middle, last name) (Current Residence or NFA)
Date of Birth: _____ PHN _____
(health number)

- The following information may be collected and disclosed about me:
 - Information on the Therapeutic Recovery Community referral form
 - Information on Island Health records that pertain to mental health and substance use, as well as records regarding physical health conditions that relate to current care needs
 - Information provided in assessments required for services
 - Additional information as specific below:

__Client History_____

Consent to the collection and disclosure of information for the purpose of assisting in my recovery about me from or to:

New Roads Women's Therapeutic Recovery Community and:

- This information may only be collected from or disclosed to:
_Island Health, Community Corrections _____

Signature of client: _____

Print client name: _____

Signature of witness: _____

Print witness name: _____

Date signed: _____

Consent for disclosure of Client Information is in effect until discharge from New Roads or until such time as the resident withdraws consent.