Indigenous Recovery Coach Program Referral Form

Referring Organizations are asked to complete the following form with as much detail as possible.
Information is collected to determine eligibility for the Indigenous Recovery Coach Program.
Please submit completed forms by email to **rc@lethbridgearches.com** or by fax to **403-328-8564.**
Referring Organizations will be contacted by the program within a week of submitting this referral package.

GENERAL INFORMATION

Name: ____

Indigenous Status: First Nations ☐ Métis ☐ Inuit ☐

D.O.B/Age: ____________________________________

Personal ID's in place: Yes☐ No☐

Alberta Health Care #: ___________________________

Referring Organization: _________________________
____

What prompted referral: ________________________
____
____
____

SUBSTANCE USE / ADDICTIONS

Active Opioid Substance Use: Yes☐ No☐

Other Active Substance Use: Yes☐ No☐
If yes, types of substances used: __________________
____

Chronicity of Use: ______________________________

History of Overdose: Yes☐ No☐

History of Relapse: Yes☐ No☐

History of Addiction Switching: Yes☐ No☐

Observed Withdrawal Symptoms: *Agitation* ☐
Seizures ☐ *Hallucinations* ☐ *Other:* ______________

Periods of Abstinence: Yes☐ No☐

Undergoing Opioid Agonist Treatment: Yes☐ No☐
If yes: Suboxone ☐ *Methadone* ☐

With which clinic (name): _______________________
____

If no, is there a desire to undergo OAT*: Yes☐ No☐*

Expected willingness to participate in recovery:
Yes☐ No☐

Expected willingness to participate in harm reduction strategies: Yes☐ No☐

CULTURAL ENAGEMENT

History of cultural engagement: Yes☐ No☐
If yes, what types of activities: ___________________
____
____

Current participation in cultural practices: Yes☐ No☐

Speaks traditional cultural language: Yes☐ No☐
If yes, which language: _________________________

FINANCIAL

Trusteeship In Place: Yes☐ No☐
If yes, who (name/number): _____________________
____

Personal Bank Account: Yes☐ No☐
If yes, list branch: ______________________________

Finances Available for Living Cost: Yes☐ No☐
If yes, source of income: _________________________

Is the Individual Currently Connected to:
AISH: Yes☐ No☐ *PDD:* Yes☐ No☐

Has the Individual Been Denied by Any Government Funding Program: Yes☐ No☐
If so, list: _______________________________________

MEDICAL / PHYSICAL HEALTH

Family Physician: Yes☐ No☐
If yes, who (name/number): ______________________
____

Pharmacy: Yes☐ No☐
If yes, list: _____________________________________

Health Insurance Coverage: Yes☐ No☐

Dentist: Yes☐ No☐
If yes, who (name/number): ______________________
____

Please list other health related supports: ___________
____

Diagnosed Medical Condition(s): Yes☐ No☐
Please list: ____________________________________

Suspected Medical Condition(s): Yes☐ No☐
Please list: ____________________________________

Currently Prescribed Medication: Yes☐ No☐
Please list:_____________________________________

Compliance Concerns: Yes☐ No☐

Does the individual frequent the emergency room for medical support? Yes☐ No☐

Date of last emergency room visit: _______________

MENTAL HEALTH

Diagnosed Mental Health Condition(s): Yes☐ No☐
Please list: ____________________________________

Suspected Mental Health Condition(s): Yes☐ No☐
Please list: ____________________________________
____

Active Psychiatrist: Yes☐ No☐

Active Mental Health Therapist: Yes☐ No☐

Currently Prescribed Medication: Yes☐ No☐
*Please list:*_____________________________________
____

Compliance Concerns: Yes☐ No☐

Has the individual visited the emergency room for mental health related concerns? Yes☐ No☐

COGNITIVE

Observed Memory Impairment: Yes☐ No☐
If yes: Short-Term: ☐ or *Long-Term:* ☐

Ability to Follow Direction: Yes☐ No☐

Ability to Predict Consequences: Yes☐ No☐

Ability to Emotionally Self-Regulate: Yes☐ No☐

Observed Problem Solving Impairment: Yes☐ No☐

Suspect or Confirmed Head Injury: Yes☐ No☐
If yes, symptomology: ___________________________
____

SAFETY

History of Harm from Others: Yes☐ No☐
If yes, date of most recent incident: _______________

History of Harm to Others: Yes☐ No☐
If yes, date of most recent incident: _______________

History of Harm or Aggression to Staff: Yes☐ No☐
If yes, date of most recent incident: _______________

History of Abuse: Yes☐ No☐
If yes, were they the: Perpetrator ☐ *Victim* ☐ *Both* ☐

JUSTICE / CORRECTIONS

History with Police Services: Yes☐ No☐

Criminal Record: Yes☐ No☐
If so, what convictions? _________________________
____

History with Court System: Yes☐ No☐

History of Incarceration: Yes☐ No☐
If so, date of last incarceration __________________
____

SUPPORTS

Guardianship in Place: Yes☐ No☐ *If yes, who (name/number):* ______________________ ____	Is the Individual Connected to Healthy Natural Supports? Yes☐ No☐ *If yes, who:* ___________________________________ ____
Enduring Power of Attorney: Yes☐ No☐ *If yes, who (name/number):* ______________________ ____	Does the Individual Have Regular Interaction with Family? Yes☐ No☐ *If yes, who:* ___________________________________ ____ *Is the family a healthy support? Yes☐ No☐*
Personal Directive Established: Yes☐ No☐ *If yes, who is named as decision maker (name/number):* ______________________________ ____ *Enacted? Yes☐ No☐*	Is the Individual Connected to Cultural Supports? Yes☐ No☐ *If yes, who/what:* ______________________________ ____
Are There Any Other Professionals/Organizations Supporting the Individual? Yes☐ No☐ *If yes, who:* __________________________________ ____	

ADDITIONAL COMMENTS / RECOMMENDATIONS

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Completed By: ______________________________ **Position:** ______________________________
(Print Name)

Signature: ______________________________ **Date:** ______________________________
(Sign Name)

Phone Number: ________________________ **Email:** ______________________________