



### KINGHAVEN REFERRAL PACKAGE

***This referral package must be completed by a drug and alcohol counsellor, a therapist, a mental health worker, a health care professional or a community support worker in collaboration with the client, not by the client on his own.***

**Before submitting your referral package, please ensure the following tasks are complete:**

- Case Manager is assigned to the client and has:
  - Filled out their contact information on page 1
  - Obtained signatures on page 4, 6 and the Pharmacare consent agreement on the last page.
  - Completed Assessments
  
- MSDSI Funding verification provided if applicable (Page 7). Client will be best served by taking this form by hand to his local MSDSI office for completion and then faxing it directly to us. Relying on faxing to the ministry may delay our receipt of the completed form and therefore delay setting up a bed confirmation and intake date.
  
- For all other funding, please see Page 2 in the referral package.
  
- Current TB test complete and attached.
  
- Review Client Checklist of What to Bring and What Not to Bring (Page 14).
  
- If the client is on medications, please ask him to bring a written prescription for 1 week to ensure he has adequate supply to last until he sees our house physician. ***Written prescriptions are mandatory for methadone.***

**Note:** If the client's Pharmacare registration is not valid or if he has a deductible he will need to self-pay for medications even if he is on MSDSI. If there is any doubt, please ask him to call Pharmacare at 604-683-7151 from Vancouver or toll free at 1-800-663-7100 from the rest of B.C. to confirm his status. ***Kinghaven does not pay for or extend credit for any medications. The client is responsible for ensuring that he has Pharmacare coverage, funds for self-pay or extended health insurance from an insurer approved by Shoppers Drug Mart for direct billing.***

- Inform client to call to Ext. 210 after 9am to check-in. Clients can leave a message and intake will respond as necessary.

#### **Admissions at Kinghaven:**

Admissions are by appointment only. Our intake times are Monday to Thursday, 10am to 12pm. We do not schedule intakes for Fridays, weekends or statutory holidays. Exceptions may be made to these schedules for clients arriving from outside the Lower Mainland/Fraser Valley area.



# KINGHAVEN TREATMENT CENTRE

## REFERRAL FORM

Date: \_\_\_\_\_

### CLIENT INFORMATION

Last Name: \_\_\_\_\_ First Name(s): \_\_\_\_\_ Middle Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 OK to speak to another member of household?  Yes  No      OK to leave message?  Yes  No

SIN: \_\_\_\_\_ PHN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Marital Status:  Single  Common Law  Married  Separated  Divorced

Concurrent Disorder  Methadone Maintenance

### REFERRING AGENCY INFORMATION

Referral Agent Name: \_\_\_\_\_ Referring Agency: \_\_\_\_\_

City: \_\_\_\_\_ Email: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please provide a brief explanation of the client's motivation and purpose in seeking treatment at Kinghaven. Include assessment of client's readiness for residential treatment, especially their ability and willingness to participate in group therapy.

How often have you seen this client?

How did this client come into your care?

What do you see are this client's personal strengths/abilities?

What are the client's treatment objectives?

List barriers you believe this client faces in achieving the treatment objectives.

List concerns you have regarding this client's ability to function in a residential treatment setting.

In your opinion, what stage of change is this client currently in?

- Pre-contemplative     Contemplative     Preparation     Action  
 Maintenance     Relapse

Please provide any additional information that may assist in determining your client's suitability for residential treatment at Kinghaven:

Referral Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FINANCIAL INFORMATION

How will the client be paying for your treatment at Kinghaven?

- MSDSI (Income Assistance)     ADS     Self Pay     Other \_\_\_\_\_

Is the client currently receiving:     EI Benefits     Pension     Other Income (if so, specify)

**If MSDSI, the Confirmation of Funding form on Page 7 must be completed, stamped and signed by the Ministry.**

If Self Pay, we accept Visa, MasterCard, Certified Cheque or Money Order. Payment is due on admittance. Please call for current rates. Please note that Employment Insurance and Canada Pension Plan do not pay for treatment.

For further information, contact the Admissions Coordinator at 604-864-0039, Ext 213.

**TREATMENT INFORMATION**

Has the client been a resident at Kinghaven before?  Yes  No When? \_\_\_\_\_

If yes, did he complete the program?  Yes  No

Has he attended other treatment centres and/or programs? Please list.  Yes  No

Reasons for leaving previous treatment:

What are his aftercare plans following treatment in terms of:

Housing: \_\_\_\_\_

Transportation home: \_\_\_\_\_

Support: \_\_\_\_\_

List areas you see that may be barriers to your client achieving his recovery goals.

What is his drug of choice?

Which other substances does he regularly use?

Alcohol

Cocaine

Crystal Meth

Methadone

Cannabis

Heroin

Benzodiazepines

Other:

**MEDICAL & MENTAL HEALTH INFORMATION**

Is the client mentally stable with no current psychiatric concerns?  YES  NO

Does the client have a history of mental illness?  YES  NO

Is the client actively suicidal?  YES  NO

Has the client been suicidal in the past six months?  YES  NO

Does the client have a history of self-injury?  YES  NO

Has the client been hospitalized in the last 30 days?  YES  NO

If yes, for what reason? \_\_\_\_\_

Has the client

Ever had a blackout?  YES  NO

Ever had a seizure?  YES  NO

Ever had an overdose?  YES  NO

Client's Height: \_\_\_\_\_ Weight: \_\_\_\_\_.

What mental health conditions has the client been treated for by a mental health professional or physician during his lifetime?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Sleep Disorder             | <input type="checkbox"/> Substance-Related Disorder      |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Other Personality Disorder | <input type="checkbox"/> Conduct Disorder                |
| <input type="checkbox"/> Bi-Polar      | <input type="checkbox"/> Psychosis                  | <input type="checkbox"/> Dissociative Disorder           |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Impulse Control            | <input type="checkbox"/> Borderline Personality Disorder |
| <input type="checkbox"/> Other _____   |   |  |

***If the client has been hospitalized for any of the above conditions in the past year please provide copies of psychiatric consultations. If the client is currently in hospital please also provide a letter from his doctor confirming that he is treatment ready and a suitable candidate for the Kinghaven or Valley House program.***

Please provide additional information for mental health conditions such as: date of official diagnosis, treatment, current mental health stability, first and last incidence of symptoms, etc.

Has the client experienced a brain injury?  Yes  No

***If yes, please attach medical information to help us determine an appropriate course of treatment.***

Is the client taking prescription medication?  Yes  No

List all medications: \_\_\_\_\_

***If yes, a prescription for one week of medications is required upon admission.***

Is the client on the methadone maintenance program?  Yes  No

Prescribing Doctor: \_\_\_\_\_ Dosage: \_\_\_\_\_

***If yes, a prescription for 1 week is required upon admission.***

If prescribed benzodiazapine or Z-drugs, clients must agree to taper down or off while they are here in consultation with the Kinghaven house doctor. Does your client agree to taper down or off from his current doses while he is attending Kinghaven?

Yes  No

(Refusal to taper down or off benzodiazepines and Z-Drugs may result in the refusal of this application?)

***Please have client sign here to confirm his agreement:*** \_\_\_\_\_

**LEGAL INFORMATION**

Current Status:  CSO  Parole  Bail  Probation  N/A

Court Dates:  Yes  No Dates:

Can these court dates be postponed until treatment has been completed?  Yes  No

Is the client currently incarcerated?  Yes  No If "Yes" - Release Date: \_\_\_\_\_

List the offences he has been convicted of (both past and present):  
\_\_\_\_\_

What support groups is he involved with, and for how long has he been involved?

Is this application for treatment a requirement of his parole package?  Yes  No

*Please be aware that clients will not be given permission to be absent from the program for court appearances. Arrangements will need to be made prior to admission for court dates to be completed or rescheduled. A copy of your client's Probation/Bail conditions needs to be submitted prior to entry into the program.*

*Please Note: If this referral is being made from a correctional institution, please attach a copy of the progress notes from any completed program and any completed assessments along with this application.*

P.O.'s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**NOTES:**

\_\_\_\_\_  
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**INFORMED CONSENT TO TREATMENT**

I, \_\_\_\_\_, agree and consent to participate in addiction and/or mental health treatments services offered and provided by *Kinghaven Peardonville House Society*. I understand that I am consenting and agreeing only to those services that *Kinghaven Peardonville House Society* staff is qualified to perform withing (1) the scope of the staff members' certification and training and (2) the scope of the certification and training of staff directly supervising the services received by clients at *Kinghaven Peardonville House Society*.

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_

Staff Witness: \_\_\_\_\_

**DECLARATION**

I, \_\_\_\_\_, hereby certify the above statements to be true to the best of my knowledge. By signing this declaration, I give consent to have information about my referral, admission and treatment shared with my referral agent or designate and my parole/probation officer, bail supervisor or designate. I further acknowledge that a treatment summary will be sent to the above noted referral agent when I leave the program at Kinghaven Treatment Centre. I acknowledge and agree that during my stay at Kinghaven I will be subject to mandatory, random drug testing at the discretion of staff.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FUNDING VERIFICATION FORM – MSDSI

Facility Name: **Kinghaven Treatment Centre**

Fax #: **(604) 864-9420**

Facility Address: 31250 King Road, Abbotsford BC V2T 6C2

Phone #: **(604) 864-0039 Ext 213**

**Clients receiving MSDSI funding:** Clients receiving assistance from the Ministry of Social Development and Social Innovation must inform their local office of their need to enter residential treatment, and must submit this Confirmation of Income form for completion. Once completed this form must be faxed back to the facility. The Ministry will be notified of the client's arrival on the date of intake by faxing the HR3319 to the Ministry of Social Development and Social Innovation.

CLIENT FULL NAME \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SIN \_\_\_\_\_

SIGNATURE OF CLIENT \_\_\_\_\_

<b>MINISTRY OF SOCIAL DEVELOPMENT AND SOCIAL INNOVATION: PLEASE COMPLETE &amp; FAX TO ABOVE NUMBER</b>		
GA# _____		
DOES CLIENT HAVE AN OPEN FILE ?	YES	NO
IS CLIENT RECEIVING ANY OTHER INCOME?	YES	NO
SOURCE OF INCOME	_____	
AMOUNT OF INCOME	_____	
IS CLIENT PENDING ANY OTHER INCOME	YES	NO
SOURCE OF PENDING INCOME	_____	
SIGNATURE OF EAW	_____	
DATE SIGNED	_____	
Completed by: _____  Signature: _____  Date: _____	<b>MINISTRY OFFICE STAMP</b>	



## HONOS ASSESSMENT (Health of the Nation Outcome Scales)

Name: \_\_\_\_\_

1. **Rate** each scale in order from 1 to 12
2. **Do not** include information rated in an earlier item except for item 10 which is an overall rating
3. **Rate** the MOST SEVERE problem that occurred during the 2 weeks prior to this rating.

**1. Overactive, aggressive, disruptive or agitated behaviour** - Include behaviour due to drugs, alcohol, dementia, psychosis, depression, etc. Do not include bizarre behaviour, rated at Scale 6

- 0 No problems of this kind during the period rated
- 1 Irritability, quarrels, restlessness etc. not requiring action
- 2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked agitation
- 3 Physically aggressive to others or animals; destruction of property, threatening manner;
- 4 At least one serious physical attack on others or on animals; destruction of property (e.g. fire-setting); serious intimidation or obscene behaviour

**Comment:** \_\_\_\_\_

### **2. Non-accidental self-injury**

- 0 No problems of this kind during the period rated
- 1 Fleeting thoughts about ending it all but little risk; no self-harm
- 2 Mild risk during the period; includes non-hazardous self-harm, e.g. wrist-scratching
- 3 Moderate to serious risk of deliberate self-harm, including preparatory acts- collecting tablets
- 4 Serious suicidal attempt and/or serious deliberate self-injury

**Comment:** \_\_\_\_\_

### **3. Problem-drinking or drug-taking:**

- 0 No problems of this kind during the period rated
- 1 Some over-indulgence but within social norm
- 2 Loss of control of drinking or drug-taking, but not seriously addicted
- 3 Marked craving or dependence on alcohol or drugs with frequent loss of control, risk taking under the influence, etc
- 4 Incapacitated by alcohol/drug problems

**Comment:** \_\_\_\_\_

**4. Cognitive problems:** Include problems of memory & understanding associated with any disorder; learning disability, dementia, schizophrenia, etc.

- 0 No problems of this kind during the period rated
- 1 Minor problems with memory or understanding, e.g. forgets names occasionally
- 2 Mild but definite problems e.g. has lost the way in a familiar place or failed to recognize a familiar person; sometimes mixed up about simple decisions
- 3 Marked disorientation in time, place or person, bewildered by everyday events; speech is sometimes incoherent; mental slowing
- 4 Severe disorientation e.g. unable to recognize familiar faces, speech incomprehensible

**Comment:** \_\_\_\_\_

**5. Physical illness or disability problems:** Include illness or disability from any cause. Include side-effects from medication; effects of drug/alcohol use; physical disabilities

0	No physical health problem during the period rated
1	Minor health problem during the period (e.g. cold, non-serious fall, etc.)
2	Physical health problem imposes mild restriction on mobility and activity
3	Moderate degree of restriction on activity due to physical health problem
4	Severe or complete incapacity due to physical health problem

**Comment:** \_\_\_\_\_

**6. Problems associated with hallucinations and delusions** irrespective of diagnosis  
Include odd and bizarre behaviour associated with hallucinations or delusions

- 0 No evidence of hallucinations or delusions during the period rated
- 1 Somewhat odd or eccentric beliefs not in keeping with cultural norms
- 2 Delusions of hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. clinically present but mild.
- 3 Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem
- 4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient

**Comment:** \_\_\_\_\_

**7. Problems with depressed mood**

- 0 No problems associated with depressed mood during the period rated
- 1 Gloomy; or minor changes in mood
- 2 Mild but definite depression and distress: e.g. feelings of guilt; loss of self-esteem
- 3 Depression with inappropriate self-blame, preoccupied with feelings of guilt
- 4 Severe or very severe depression, with guilt of self-accusation

**Comment:** \_\_\_\_\_

**8. Other mental and behavioural problems:** Specify the type of problem by circling the appropriate letter both here and on the score sheet: A phobic; B anxiety; C obsessive-compulsive; D stress; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify

- 0 No evidence of any of these problems during period rated
- 1 Minor non-clinical problems
- 2 A problem is clinically present at a mild level, e/g patient/client has a degree of control
- 3 Moderately severe level of problem; Occasional severe attack or distress, with loss of control
- 4 Severe problem dominates most activities

**Comment:** \_\_\_\_\_

**9. Problems with relationships:** Rate most severe problem associated with active or passive withdrawal from social relationships and/or non-supportive, destructive or self-damaging relationships

- 0 No significant problems during the period
- 1 Minor non-clinical problem
- 2 Definite problems in making or sustaining supportive relationships; evident to others
- 3 Persisting major problems due to active or passive withdrawal from social relationships, and/or relationships that provide little or no comfort or support
- 4 Severe and distressing social isolation and/or withdrawal from social relationships

**Comment:** \_\_\_\_\_

**10. Problems with activities of daily living:** e.g. eating, washing, dressing, toilet; complex skills - budgeting, finding housing, recreation, use of transport, shopping, etc. Include any lack of motivation for using self-help opportunities as this contributes to a lower overall level of functioning.

- 0 No problems during the period rated; good ability to function in all areas
- 1 Minor problems only: e.g. untidy, disorganized
- 2 Self-care adequate but major lack of performance of one or more complex skills (see above)
- 3 Major problems in one or more area of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills
- 4 Severe disability or incapacity in all or nearly all areas of self-care and complex skills

**Comment:** \_\_\_\_\_

**11. Problems with living conditions and daily domestic routine:** Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and opportunities to use intact skills and develop new ones?

- 0 Accommodation and living conditions are acceptable;
- 1 Accommodation is reasonably acceptable although there are minor problems
- 2 Significant problems with one or more aspects of the accommodation
- 3 Distressing multiple problems with accommodation; e.g. some basic necessities absent; housing environment has minimal or no facilities to improve patient's independence
- 4 Accommodation is unacceptable:

**Comment:** \_\_\_\_\_

**12. Problems with occupation, activities in daytime environment.** Is there help to cope with disabilities? Are there opportunities to maintain/improve skills and activities? Consider stigma, access to supportive facilities and qualified staff.

- 0 Patient's day-time environment is acceptable and supportive of self-help
- 1 Minor or temporary problems requiring little action e.g. late cheques; reasonable facilities available but not always at desired times, etc.
- 2 Limited choice of activities – lack of permanent address or insufficient career or professional support; helpful day setting available but for very limited hours
- 3 Marked deficiency in skilled services available to help minimize level of existing disability; no opportunities to use intact skills or add new ones;
- 4 Lack of opportunity for daytime activities makes patient's problems worse

**Comment:** \_\_\_\_\_

<b>HoNOS Score Sheet</b>			
	<b>Rate 9 if not known</b>		<b>Rate</b>
<b>1</b>	Overactive, aggressive, disruptive behaviour	<b>0 1 2 3 4</b>	
<b>2</b>	Non-accidental self-injury	<b>0 1 2 3 4</b>	
<b>3</b>	Problem-drinking or drug-taking	<b>0 1 2 3 4</b>	
<b>4</b>	Cognitive problems	<b>0 1 2 3 4</b>	
<b>5</b>	Physical illness or disability problems	<b>0 1 2 3 4</b>	
<b>6</b>	Problems with hallucinations and delusions	<b>0 1 2 3 4</b>	
<b>7</b>	Problems with depressed mood	<b>0 1 2 3 4</b>	
<b>(Specify disorder A,B,C,D,E,F,G,H,I, or J)</b>			
<b>8</b>	Other mental & behavioural problems	<b>0 1 2 3 4</b>	
<b>9</b>	Problems with relationships	<b>0 1 2 3 4</b>	
<b>10</b>	Problems with activities of daily living	<b>0 1 2 3 4</b>	
<b>11</b>	Problems with living conditions	<b>0 1 2 3 4</b>	
<b>12</b>	Problems with occupation and activities	<b>0 1 2 3 4</b>	

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**GAIN ASSESSMENT**

Date: \_\_\_\_\_

Name: a. \_\_\_\_\_ b. \_\_\_\_\_ Age: \_\_\_\_\_  
 (First name) (Last Name)

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for **two or more weeks**, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following statements, please tell us the last time you had this problem, if ever, by circling the appropriate corresponding number.

Past month	2 to 12 months ago	1 + years ago	Never
3	2	1	0

1. When was the last time you had significant problems...
  - a. With feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? 3 2 1 0
  - b. With sleeping, such as bad dreams, sleeping restlessly or falling asleep during the day? 3 2 1 0
  - c. With feeling very anxious, nervous, tense, fearful, scared, panicked or like something bad was going to happen? 3 2 1 0
  - d. When something reminded you of the past and you became very distressed and upset? 3 2 1 0
  - e. With thinking about ending your life or committing suicide? 3 2 1 0
  
2. When was the last time you did the following things two or more times?
  - a. Lied or conned to get things you wanted or to avoid have to do something? 3 2 1 0
  - b. Had a hard time paying attention at school, work or home? 3 2 1 0
  - c. Had a hard time listening to instructions at school, work or home? 3 2 1 0
  - d. Were a bully or threatened other people? 3 2 1 0
  - e. Started fights with other people? 3 2 1 0
  
3. When was the last time...
  - a. You used alcohol or drugs weekly? 3 2 1 0
  - b. You spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high or sick)? 3 2 1 0
  - c. You kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? 3 2 1 0
  - d. Your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events? 3 2 1 0
  - e. You had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems? 3 2 1 0
  - f. Had a disagreement in which you pushed, grabbed or shoved someone? 3 2 1 0
  - g. Took something from a store without paying for it? 3 2 1 0
  - h. Sold, distributed or helped to make illegal drugs? 3 2 1 0
  - i. Drove a vehicle while under the influence of alcohol or illegal drugs? 3 2 1 0
  - j. Purposely damaged or destroyed property that did not belong to you? 3 2 1 0

Do you have other significant psychological, behavioural or personal problems you want treatment for or help with?  YES  NO

If yes, please describe: \_\_\_\_\_

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## Things to Know

Please give this to clients:

We look forward to having you here at Kinghaven. To make your treatment experience as smooth as possible, this is a list of things to know before you arrive:

1. Admissions are by appointment only. Our intake days are Monday to Thursday mornings. We do not schedule intakes for Fridays, weekends or statutory holidays. Exceptions may be made for clients arriving from outside the Lower Mainland/Fraser Valley area.
2. Call us every day between 9:00-10:00am to check in. ***Failure to check in may result in removal from the waiting list.*** Call 604-864-0039, Ext 210. Our toll free line is 1-877-864-0039.
3. If you are on medications, please bring a new, written prescription for 2 weeks to ensure you have adequate supply to last until you see our house physician. ***Do not bring your own medications.***
4. If you are on methadone, bring a new, written prescription with the original hard copy for 2 weeks to ensure you have adequate supply until you see our house physician. ***If you arrive without a new methadone prescription you may be denied admission.*** We cannot assist you in obtaining a new prescription after your arrival until you see our house doctor.
5. ***Protein powders are not permitted.*** If you need a specialized protein diet it will be developed by our dietician and kitchen staff to meet your needs.
6. Do not bring over-the-counter medications including vitamins. If these are needed they will be prescribed by our house doctor, purchased from our pharmacy at your expense and administered by staff along with other medications. No prescribed or over-the-counter medications are permitted to be kept in your room or on your person except by special permission.
7. ***Kinghaven does not pay for or extend credit for any medications. All medication costs must be paid in advance before we will order them from Shoppers. You are responsible for ensuring that the costs of your medications are covered by Pharmacare, Extended Health Insurance or self-pay. If there is any doubt, confirm your status by calling Pharmacare at 604-683-7151 or 1-800-663-7100. Note that Shoppers does not always bill direct to your insurer. In such cases you will need to pay in advance and then seek reimbursement from your insurer on your own.***
8. If you bring a cell phone it will be locked up in safekeeping for the duration of your stay. You will not have access to it until you leave. If you have any important phone numbers stored on it, write them down ahead of time. You will have access to payphones during your stay. The payphones are set up for outbound and inbound calls.

9. If you are a client of the Ministry of Social Development on regular assistance or disability (PWD) you receive a comfort allowance of \$95 per month while you are at Kinghaven (unless you owe them money in which case they may make a deduction from your allowance). You do not receive your full benefits. If you arrive near the end or beginning of the month and have already received your full cheque, you may be required by the Ministry to pay an amount to us on their behalf, usually equal to your comfort allowance minus the amount of your cheque.

10. Hair cutting is not allowed. If you bring hair cutting or beard trimming equipment with you it will be confiscated, placed in safekeeping and returned to you when you leave.

11. **Due to Fraser Health licensing regulations, food is not allowed anywhere except in the cafeteria.** Food cannot be kept in rooms. If you bring food with you (or back with you from any off-site visits) you will need to consume it before we will assign you to a room or it will be confiscated and disposed of. We do not store food.

12. If you are arriving via Greyhound, call us at 604-864-0039, Ext 210 from the Abbotsford depot when you arrive. We do not meet buses so you need to call us to let us know you are there. We'll pick you up as soon as possible after your call.

**12. Do not bring** cell phones (even if they don't work), any wifi-capable devices (even if they don't work), DVD players, personal gaming devices, televisions, stereos, bedding, towels, valuables or breakables, over the counter medications including vitamins and protein powders, mouthwash, hair clippers or beard trimmers. Any of these items will be locked up in safe keeping for the duration of your stay and will not be accessible to you under any circumstances.

**13. Do bring** alcohol-free personal hygiene products (shampoo, soap, toothbrush, etc), comfortable and appropriate clothing and footwear including athletic wear, personal identification, a small alarm clock, a clear water container, telephone card to use the payphones, tobacco products for a minimum 3 weeks, and \$10.00 linen deposit. You will need money for laundry. Detergent can be purchased from Kinghaven but you may wish to bring your own.

14. Due to space restrictions, clients are permitted 1 suitcase and 1 small bag of possessions. Excess belongings will be sent home. All bags will be searched.

15. Vehicles, bicycles and other modes of personal transportation are not permitted while you are at Kinghaven. Please leave them behind.



PHARMANET Patient Consent to Access PharmaNet Kinghaven Treatment Centre

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, and which may be continued pursuant to section 13 of the Pharmacy Operations and Drugs Scheduling Act, S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, \_\_\_\_\_, authorize Dr. Johan Wouterloot

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physicians.

Executed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

SIGNED AND DELIVERED by

\_\_\_\_\_  
Patient(print)

in the presence of:

\_\_\_\_\_  
Witness (signature)

\_\_\_\_\_  
Witness (print)

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Patient (signature)