



Date of Referral: _____

Participant Name: _____

A:yelexw Referral Form

WHAT: A:yelexw (Halq'emeylem, meaning 'in good health') is a residential recovery centre for Indigenous adults living in the Fraser Valley. A:yelexw has 13 beds in a home-like context for adults who are struggling with complex addictions and mental health concerns. Programs and services are firmly grounded in Indigenous practices.

HOW: A:yelexw offers a flexible stay of up to one year and long term follow-up for as long as the participant wishes to engage.

An Individual Recovery Plan is created with each participant: individual work or one-to-one work (e.g. mental health and addictions counselling, medical and traditional healing, employment and vocational plans) as well as group work (e.g. On the Land, Relationships, Anger Management, Life Skills, and Managing Th'oxweya (addictions)).

Household chores are assigned to both participants and staff who work alongside each other. Chores include inside work, such as cooking/cleaning, and outside work, such as maintaining the garden/lawns/outdoor areas.

WHO: A:yelexw programs and services are offered in partnership between Fraser Health, Seabird Health and Chilliwack Community Services. On-site detox is offered in partnership with Riverstone if indicated.

YOU: You are a willing participant, voluntarily taking up residence at A:yelexw. You identify as Indigenous and are 19 years or older. You play a role in your individual recovery plan and commit to the actions outlined in your recovery plan.

----- Seabird Island Health -----

2895 Chowat Road. P.O. Box 765, Agassiz, BC V0M 1A0 Telephone (604) 796-2177 Fax (604) 796-3729

A:yelexw Participant Name: _____

Referral Criteria

A referral may be made by a Fraser Health Community Substance Use Services clinician

A referral may be made by Fraser Health Concurrent Disorder therapists

A referral may be made by the National Native Alcohol and Drug Abuse Program

This form is completed with both the referring professional and participant cooperation.

Admission Criteria

- Participants are willing participants, voluntarily taking up residence at A:yelexw
- Participants identify as Indigenous and are 19 years or older
- Participants play a role in their individual recovery plan and commit voluntarily to the actions outlined in their recovery plan
- Independence in daily living activities – eating, toileting, transferring and mobility.

Exclusion Criteria

- Arson / fire setting
- Sexual activities involving minors
- Severe violence

Referral Source

<input type="checkbox"/> Fraser Health Community Substance Use Services	<input type="checkbox"/> National Native Alcohol and Drug Abuse Program
<input type="checkbox"/> Fraser Health Concurrent Disorder.	<input type="checkbox"/> Other:

Name of referring agent: _____

Agency & Title: _____

Telephone Number: _____

Email: _____

Funding Source (for \$40 per day living costs)

Self pay	
Workplace benefits / health plan	
Income Assistance	
NNADAP / First Nations Health Authority	
Fraser Health	
Other _____	

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A:yelexw Participant Name:

Participant Information

Participant's Legal Name:			Preferred Name(s):	
Gender:	Birthdate:	Age:	Marital Status:	# of Children:
Address:				
City:	Province:	Postal Code:		
Telephone:	Email:			
Status #:	Provincial Health Number:	Band:		
Emergency Contact Name:				
Relationship:	Telephone:	Email:		

Substance Use Services History

Please list any previous recovery / treatment / counselling / detox services:

Location	Date

Participant identified goals for recovery:

A:yelexw Participant Name:

History of Substance Use

Please fill this section in completely. Please put N/A if not applicable

	Drug of choice (check top 3)	Primary or Route	Date last used (DD /MM/YY)	# Days used in last 30 days	Typical amount used daily	Age at 1st use
Alcohol						
Amphetamines						
Benzo						
Cannabis						
Cocaine						
Crack cocaine						
Crystal meth						
Fentanyl						
Hallucinogens						
Heroin						
Inhalants						
Opioids						
Tobacco						
Other – please specify						
Gambling						
Sexual activity						
Pornography						
Shopping						

Psychiatric History

Has the participant been referred to or consulted with a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a diagnosis been confirmed by a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please attach the most recent psychiatric assessment.	
Has the patient received care for other mental health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide a brief description:	
Psychiatrist name:	Contact number:
Mental health worker name:	Contact number:

A:yelexw Participant Name: _____

Medical History

Diagnosis	Date of diagnosis	Indications	Medications
HIV <input type="checkbox"/>			
Hepatitis C <input type="checkbox"/>			
Seizures <input type="checkbox"/>			
- due to substance use? <input type="checkbox"/>			
- due to medical condition? <input type="checkbox"/>			
- if yes, please identify _____			
Last TB test - attach results <input type="checkbox"/>			
FASD <input type="checkbox"/>			
Past surgeries <input type="checkbox"/>			
Head injury <input type="checkbox"/>			
Mobility <input type="checkbox"/>			
Cognitive impairment <input type="checkbox"/>			

Please list prescription and non-prescription medications used by the participant.

A:yelexw Participant Name:

Potential Safety Concerns

Yes / No		Summary and most recent incident
Suicide ideation / Suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Self harming	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Aggression / anger	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Risk taking	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Potential Challenges

Yes / No		Summary and most recent incident
Participating in a group setting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning challenges	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Justice

Criminal record	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Details:
On probation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Details:
Probation officer name		
Charges pending	<input type="checkbox"/> Criminal <input type="checkbox"/> Family <input type="checkbox"/> Both <input type="checkbox"/> N/A	Details:
Upcoming court dates		Details:

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