A:yelexw Referral Form

Complete this package and submit to ayelexw@seabirdisland.ca

WHAT: A:yelexw (Halq'emeylem, meaning 'in good health') is a Residential Recovery Centre for Indigenous adults living in the Fraser Valley and some other parts of B.C. A:yelexw is a home-like context for adults who are struggling with complex addictions and mental health concerns. The Men's Home has 13 beds; the Women's Home has ten beds. Programs and services are firmly grounded in Indigenous practices as well.

HOW: A:yelexw offers a 3 month clean and sober, safe and supportive place. FNHA funding: Extensions can be applied for and this will determine the length of stay in our program. Also, there can be follow-up care for as long as the participant wishes to engage.

An Individual Recovery Plan is created with each participant: one-on-one work (e.g. mental health and addictions counseling, 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.

On admission, staff will conduct an inventory of your belongings. See What Not to Bring. http://www.seabirdisland.ca/index.php/service/ayelexw-center-for-hope-and-healing/

WHO: A:yelexw programs and services are offered in partnership between Fraser Health, Seabird Health and Chilliwack Community Services.

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.

Referral Process

Application Date:_____

A referral may be made by a Fraser Health Substance Abuse or Concurrent Disorders clinician
A referral may be made by a community health or addictions worker
This form is completed with both the referring professional and participant.
The form, once completed, is submitted to ayelexw@seabirdisland.ca

Admission Criteria

- ☐ Participants are voluntarily living at A:yelexw, and committing to their recovery plan
- ☐ Participants identify as Indigenous and are 19 years or older
- ☐ Participants are independent in daily living activities – eating, toileting, and mobility.
- ☐ Participants have been drug and alcohol free for 72 hours

Exclusion Criteria

- ☐ Arson/fire setting; Sexual activities involving minors; Severe violence to self or others

Referral Source

☐Fraser Health ☐Community health worker
☐Community addictions worker ☐Other: _____

Name and title of person referring: _____
Telephone _____; Email _____

Participant Information

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

Substance Use Recovery or Treatment History

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

Location	**Did client complete?**	**Date**

History of Substance Use

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

	Drug of choice (circle top 3)	Route Inhale/ Inject etc.	Date last used (DD /MM/YY)	# Days used in last year	Typical amount used daily	Age at 1st use	Stage of change withdrawal/detoxing tapering/recovery Please indicate below
Alcohol							
Amphetamines							
Benzo							
Cannabis							
Cocaine							
Crack cocaine							
Crystal meth							
Fentanyl							
Hallucinogens							
Heroin							
Inhalants							
Opioids							
Tobacco							
Other – please specify							
Gambling							
Sexual activity							
Pornography							
Shopping							

History of other addictive behaviour: (e.g. gambling, eating disorder etc.)

Psychiatric/Mental Health History

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

Medical History

Diagnosis		Date of diagnosis	Details	Medications
HIV	☐			
Hepatitis C	☐			
Seizures	☐			
FASD	☐			
Brain injury	☐			
Last TB test - attach results	☐			
Chronic conditions	☐			
Cognitive impairment	☐			
Uses mobility aides	☐			
Requires personal care assistance	☐			
Allergies	☐			

Medications

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

Please attach the participant's medication list, if applicable. ☐ Yes ☐ N/A

Clients on Methadone or Suboxone must provide details about the prescriber below:

Doctor:	Contact:	Office Location:

Medical Review

If possible, have client's physician fill out approval below

When needed, medical review can be accomplished through Seabird medical clinic

☐ This client requires medical screening by Seabird Medical clinic

MEDICAL APPROVAL			
In your opinion is this person medically/mentally stable and appropriate for admission to Residential Recovery? □ No □ Yes			
PHYSICIAN'S NAME	SIGNATURE	DATE YYYY/MMM/DD	PHYSICIANS STAMP

Challenges / Safety Concerns

		Summary and/or comments
Participating in a group setting	☐ Yes ☐ No	
Suicide ideation Suicide attempts	☐ Yes ☐ No	
Self-harming	☐ Yes ☐ No	
Aggression / anger	☐ Yes ☐ No	
Domestic violence	☐ Yes ☐ No	
Risk taking	☐ Yes ☐ No	
Learning challenges	☐ Yes ☐ No	

Justice

Criminal record	☐	Details:
On probation	☐	Details:
Probation officer name		
Charges pending ☐Criminal ☐Family	☐	Details:
Upcoming court dates ☐Criminal ☐Family	☐	Details:

Participant identified goals for recovery

1.
2.
3.
4.

Funding Information

Funding source is to be identified before admission

Please choose the best options from below. Unless you have advanced funding approval, please complete Fraser Health (FH) subsidy application IN ADDITION TO the best options below: **Note: Social Assistance does not pay the cost of this program, please apply for one of the subsidies mentioned below for your client. No self-referrals are accepted from the client or by the subsidy agencies thereof. Client must have a referring agent.**

- ☐ Please fill out FH subsidy application, available by calling SUSAT clinician to help you apply for Fraser Health Funding for your client. 1-866-624-6478. (for Fraser Region applicants only)
- ☐ Participant has Status as First Nations. Please fill out First Nations Health Authority subsidy application form, available using link. http://treatment.fnha.ca/
- ☐ Participant has extended benefits coverage. Please email confirmation notice.
- ☐ Participant will self-pay. Please email a signed letter from participant with payment/banking details. (Payments are due in-advanced for every 30 days in home).
- ☐ Participant has subsidy approved from their Band. Please email proof of approval from Band.
- ☐ Participant has no source of funding