Bridgeway
Recovery & Addiction Services
Application

For program inquiries please contact Bridgeway at
250-763-0456 extension 2402 | bridgeway@thebridgeservices.ca | www.thebridgeservices.ca

Please fax completed application to Bridgeway at:
Fax: 250-491-7331

Bridgeway Recovery & Addiction Services
265 Gray Road, Kelowna, B C
V1X 1W8

REFERRAL ADMISSION GUIDELINES & INFORMATION

☐ Check here if also applying for Supported Recovery post treatment.

If applying to Supported Recovery only, please complete separate application which can be found on our website www.thebridgeservices.ca .

- Self referrals are not accepted.
- Please complete the application in full ((Funding confirmed, Medical Forms completed and recent negative TB Skin Test attached) as incomplete referrals may not be processed.
- The referral source completes the application in collaboration with the applicant.
- Please review our Referral & Admissions Criteria.
- Please review and discuss our Program Description with your client. This can be found online at (www.thebridgeservices.ca).
- Bridgeway is not a medical facility, therefore, a minimum of 7 days substance free is recommended as participants must be capable of participating in programming upon admission. Participants arriving that require a medical withdrawal management program cannot be admitted.
- All participants will be drug tested during intake
- Referrals from correctional facilities must have a release date as without one, applications can not be accepted.

APPLICANT ADMISSION GUIDELINES

- Self referrals are not accepted.
- When all your information is received and you are determined eligible for admission you will be contacted.
- The Preadmission Medical Status Questionnaire and the Prescription Form must be completed by a physician and may be faxed in separately to Bridgeway.
- Methadose/Suboxone/Kadian applicants must come with their original Triplicate prescription with them upon admission. Triplicate prescriptions need to be for the duration of the program.
- Please bring along any 3rd Party Insurance Coverage information should you have as you are responsible for the cost of your medications both prescribed and over the counter.
- If funded by the Ministry of Social Development & Poverty Reduction please take the Ministry's funding form into your local Social Assistance office for completion.
- Please include a copy of your TB Skin Test typically obtained through Public Health. This test must have been completed within six months of the admission date.

COVID-19 ADMISSION GUIDELINES

In keeping in line with provincial COVID health recommendations there are a few announcements and guidelines that applicants need to be aware of.

1. Upon arrival all participants will have a Screening Assessment for COVID-19. This consists of temperatures taken, along with a series of questions pertaining to symptoms/exposure. These will include:

   a. Are you experiencing a fever, chills, cough, shortness of breath, sore throat, pneumonia etc.?

   b. Have you ever travelled outside of Canada within the last 14 days?

   c. Have you been instructed in the last 14 days to self-isolate?

   d. Did you provide care or have close contact with a person with COVID-19 (probable or confirmed)?

   e. Has anyone in your household been sick in the last 14 days?

   f. Have you been tested for COVID-19 and results are pending?

   g. Do you work in any other setting where cases of COVID-19 have been diagnosed or an outbreak declared (e.g. meat processing plant, other setting)? Do you live with anyone who works in such a setting?

2. There are a few additional protective measures that will be implemented.

   a. There are no weekend passes.

   b. There will be very limited off site supervised outings.

   c. Participants will be required to wear a face masks for the first 14 days. These will be provided.

These measures and guidelines are in place to ensure the safety of both participants and staff. We will adhere to provincial standards and as measures change we will adjust.

Please review this with your client before they arrive here. If they answer yes to the screening questions, have them see a medical professional and cleared for treatment. Otherwise they will be turned away at the door to ensure the safety of the program.

Sincerely,

The Bridgeway Team

REFERRAL FORM

Date of referral (day/month/year):

Applicant's Legal Name:	Preferred Name(s):

Referral & Admission Criteria

- *A referral may be made by any member of the applicant's care team but applicants **must be connected to a community based Substance Use treatment team**. It is acknowledged that not everyone requires facility based services and it is important to ensure that it is the most beneficial service setting to address a person's problematic substance use prior to being admitted.*
- *Bridgeway's Intensive Facility Based Treatment Program should be considered only for individuals with more complex and/or chronic substance use which has impacted many areas of their life and that **community based treatment approaches have been exhausted prior to considering our services.***
- *Applicants must be a BC resident age 19 and older and independent in activities of daily living.*
- *Applicants who reside outside of the IHA catchment area will be waitlisted for possible availability and consideration only at intake.*

REFERRAL INFORMATION

Health Authority: Interior ☐ Fraser ☐ Northern ☐ Island ☐ Vancouver Coastal ☐ Other ☐

Referral Source and Organization:	
Address:	City & Postal Code:
Telephone:	Fax:
Email Address:	
Please indicate how long you have been working with your client? _____	
Your clients number of individual therapy sessions for addictions and mental health issues in the last three months?____	
Please indicate the number of group counseling sessions over the past three months your client has attended? ____	
Please indicate the specific groups your client has attended: If none please explain why:	
Case Manager's Name and Organization: (if different from Referral Source):	
Is applicant's Case Manager aware of this application? Yes ☐ No ☐ (If no, please advise them now)	
Address:	
Telephone:	Fax:

CLIENT INFORMATION

Female: ☐	Male: ☐	Transgender: M/F ☐ F/M ☐	Preferred pronoun:
Date of Birth (day/month/year)	Age:	BC Care Card #::	
Address:		SIN:	
City:	Province:	Postal Code:	
Telephone:	Email:		
O.K. to speak to other members of household: Yes ☐ No ☐			
Please indicate your client's highest educational level completed:			

Marital Status:	Single ☐	Married ☐	Common Law ☐	Divorced ☐	Separated ☐	Widowed ☐
Pregnant: Yes ☐ No ☐			Pregnancy Due Date:			
Does your client have minor children? (under 19)			Yes ☐		No ☐	
Names (write below)		Age (write below)	What is the child's current living situation? (write below)			
Is your client the custodial parent?				Yes ☐	No ☐	
If no:	Who has custody of child(ren)?					
Has your client been mandated to treatment by MCFD?				Yes ☐	No ☐	

CULTURAL INFORMATION

Ethnicity:	First Language:	
Are there barriers any to communication? Yes ☐ No ☐		
If yes, please specify:		
Any cultural specific care/ practice: Yes ☐ No ☐		
If yes, please specify:		
Aboriginal Ancestry: Yes ☐ No ☐	Status: ☐	Non-Status ☐

Status Number: _____ Do you live on Reserve?: Yes ☐ No ☐

Please specify; Band Name, Inuit, Metis, Aboriginal Community: _____

EMERGENCY DESIGNATED CONTACT PERSON (Family/Friends)

Name:	Relationship:
Telephone:	Email:
Address:	

SUBSTANCE USE TREATMENT HISTORY

Has your client completed a withdrawal management program?	Yes ☐	No ☐
If yes, please list dates and where: If no, date of last substance use: Is a Withdrawal Management Program prearranged?		
Prior Treatment and/or Counselling History (Please list all previous treatment and dates):		

Name of Agency	City	Start & End Dates	Completed
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

If no previous facility based treatment history, why?

Please provide a brief explanation of your client's motivation and purpose for seeking treatment at Bridgeway:

Bridgeway applicant: In your own words, please explain why you wish to attend Bridgeway?

HISTORY OF SUBSTANCE USE CONCERNS

Substance	Method of Use (Inject, smoke, snort, ingest)	Date last used (Day / Month / Year)	# Days of use in last 30 days	Typical amount/quantity used daily	Age at first use
Alcohol					
Non-beverage Alcohol (mouthwash/other)					
Tobacco					
Cannabis/cannabis derivatives					
Crack Cocaine					
Cocaine					
Heroin					
Fentanyl					
Non Prescribed or Misused Opioids					
Non Prescribed or Misused Benzos					
Crystal Meth					
Amphetamines					
Hallucinogens					
Inhalants					
Steroids					
Other					

HISTORY OF PROCESS CONCERNS

Process	Date last active	# of days active in last 30	Age at first experience
Pornography Addiction			
Shopping Addiction			
Sexual Addiction			
Other Addiction i.e. Gambling/Internet (Please Specify)			
Disordered Eating: □ Binging			
□ Purging			
□ Restricting			

Participants must be capable of participating in programming upon admission; 7 days substance free is recommended. Participants arriving that require a withdrawal management program cannot be admitted.

SAFETY CONCERNS

Suicide Ideation/Suicide attempts: Yes ☐ No ☐	**If yes, please summarize and date most recent.**
Self-Injurious Behaviour: Yes ☐ No ☐	**If yes, please summarize and date most recent.**
Overdoses: Yes ☐ No ☐	**If yes, please summarize and date most recent.**
Aggression/anger: Yes ☐ No ☐	**If yes, please summarize and date most recent.**
Current domestic violence: Yes ☐ No ☐	**If yes, please summarize and date most recent.**

At Bridgeway we try to accommodate all medical needs. For Medical Marijuana, we review all applicants on an individual basis and decide if they can fit into the program while still adhering to our standards of abstinence.

HOUSING / ACCOMMODATIONS

Does your client currently have safe housing? Yes ☐ No ☐ If no, please describe safety concerns:

Is your client currently homeless? Yes ☐ if so please describe situation:

Does your client have safe housing/accommodations arranged for after Bridgeway? Yes ☐ No ☐
If no, please indicate any housing referrals recently submitted for your client:

How will your client travel home?

LEGAL HISTORY / STATUS INFORMATION

Referrals submitted from Correctional Facilities **will not be accepted with unknown release dates**. Please only submit a completed referral package once release date has been set.

Does the client have any criminal history: Yes ☐ No ☐

If yes, this form **must** be completed.

Has your client ever been convicted of a violent crime: Yes ☐ No ☐

If Yes, please provide details:	

For client safety and the continuity of programming clients may not be able to attend court dates while at Bridgeway.

Does your client have any Charges Pending? Yes ☐ No ☐

Upcoming court dates?	

Are you on Parole? Yes ☐ No ☐ Are you on Probation? Yes ☐ No ☐

Currently Incarcerated? ☐ No ☐ Yes – release date is: _____

Probation/Parole Officer Name: _____

Phone: _____ Fax: _____

Please list previous/current charges and dates:

Date	Specific Charge	Sentence

Has the client ever served Federal time? Yes ☐ No ☐ If yes, have they reached warrant expiry? Yes ☐ No ☐

I consent for Bridgeway to release and exchange any pertinent information regarding my legal history with any legal agencies associated with me. (i.e. lawyer, probation officer etc.)

Client Name: _____
(please print)

Client Signature: _____ Date Signed: _____

PSYCHIATRIC HISTORY

Psychiatric Diagnosis:
☐ Depressive Disorder
☐ Bipolar Disorder
☐ Personality Disorder (please specify):
☐ Schizophrenia or other psychotic disorder:
☐ Anxiety Disorder
☐ Eating Disorder
☐ PTSD
☐ Other:
Is your client's disorder stable? Yes ☐ No ☐ and if Yes for how long? Is there any impact on daily life? If so, please explain:

MEDICAL HISTORY

Has your client been hospitalized in the last 30 days? Yes ☐ No ☐ **If yes, please detail below reason for hospitalization and <u>attach the hospital's discharge summary:</u>**
History of seizures: Yes ☐ No ☐If yes, please explain:
Last TB Test - **<u>Attach results with this form</u>** (Chest x-ray, Mantoux skin test). Must be completed within the **past six months** prior to admission.
Past Surgeries (Date) : Yes ☐ No ☐ If yes, please detail below
Mobility Issues: Yes ☐ No ☐ If yes, please detail below
Cognitive Impairment: Yes ☐ No ☐ If yes, please detail below
Head Injury (due to assault, MVA, concussion or unconscious) Yes ☐ No ☐ If yes, please detail below
FASD: Yes ☐ No ☐ If yes, please detail below

PRE-ADMISSION MEDICAL STATUS QUESTIONNAIRE

To Be Completed By a Physician

Patient Information:

First Name: _____ Last Name: _____

Health Card #: _____ Date of Birth: _____

Province: _____ Patient Phone #: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

Drug/Food Allergies: _____

Medication:
Please check all categories representing types of prescription medication that are currently being used:

☐ Anti-depressants ☐ Anti-anxiety ☐ Anti-psychotic ☐ Pain medication

☐ Other (specify): _____

Methadose/Suboxone/Kadian:

Length on Methadose program: _____ Current dose: _____ ml.

Length on Suboxone program: _____ Current dose: _____ mg.

Length on Kadian program: _____ Current does: _____ mg.

Length of time on current dose: _____

Prescribing Physician's name: _____

Phone number: (___) _____

Medical History:

Symptoms/conditions/diagnosis:	

Has patient suffered seizures in the past year: Yes ☐ No
If yes, were these seizures withdrawal related: Yes ☐ No
If not withdrawal related, do they have a seizure disorder: Yes ☐ No
If yes, please describe: _____

This patient is medically and physically capable of participating in an intensive facility based treatment program for substance misuse.

_____ _____
Doctor's Name Date

_____ _____
Phone Number Fax Number

Bridgeway (fax 250-491-7331)

PRESCRIPTION FORM

Bridgeway Recovery & Addiction Services

To Be Completed By a Physician

Dear Doctor: *Bridgeway (fax 250-491-7331)*

Your patient has applied to attend Bridgeway's Recovery & Addiction Services. Please write out all orders to facilitate admission to our program. We require applicants to **bring originals of all triplicate prescriptions or they may be faxed in directly on or before their admission date.**

Bridgeway is **42 days in length**.

Date: _____

Patient Name: _____

PHN #: _____

DOB: _____

Drug Allergies: _____

R_{χ}:

Medication	Instructions for Use	ORDERS AUTHORIZED FOR 42 DAYS UNLESS OTHERWISE SPECIFIED – PLEASE SPECIFY QUANTITY FOR NARCOTICS

Physician's Signature: _____

Physician's Name (please print): _____

License #: _____

Telephone Number: (___) _____

All medications must comply with our medication administration policies.

FUNDING INFORMATION

There is a per diem cost for Bridgeway Recovery & Addiction Services of $40 per day for 42 days for a total of **$1680.00**
There are several ways to receive funding:

- If on Income assistance an application can be made to Ministry of Social Development & Poverty Reduction (form attached). **Rent is covered while in treatment (maximum allowable is $375 per month) and a comfort allowance only is issued. Please discuss this with your client.**
- A First Nations person with status can apply to the First Nations Health Authority (Suite 540 - 757 West Hastings Street Vancouver BC V6C 1A1 Tel 604-693-3261 fax 604-666-3867) or they may be able to approach their band for funding. Confirmation from funder in writing is required.
- Self pay. The applicant must be prepared to pay the full amount upon admission. Please review our refund policy below
- Extended benefits. Bridgeway requires a letter from the applicant's provider to accompany this application.
- Applicants may apply to their health authority through their Case Manager/Counsellor for an Accommodation Fee Subsidy for partial or full payment. See your case manager for details.
- All participants are responsible for paying for all medications while in the program.

Treatment program for _____ will be paid (please check one box below):
Applicants Name, please print

☐ Applicant/Family Paid – Please provide the following information:

Name (if different than above):_____

Address: _____

Phone: _____

Email address: _____

☐ Ministry of Social Development & Poverty Reduction - Please complete the form on the next page.

☐ Accommodation Fee – **Please attach** the relevant Health Authority Accommodation Fee Subsidy Approval form.

☐ Employer Paid – **Please attach letter from employer confirming**.

Employer: _____

Contact: _____

Address: _____

Phone: _____

Email address: _____

☐ First Nations Health Authority – **Please attach** confirmation.

☐ Other _____

Refunds are made only if the client leaves Bridgeway Recovery & Addiction Services within the first week (7 days). Refund is 50% of the full fee, payable only to the person/organization that paid the fee. Fees are non-refundable after the first week.

MINISTRY OF SOCIAL DEVELOPMENT & POVERTY REDUCTION
FUNDING VERIFICATION REQUEST FORM

TO: BRIDGEWAY APPLICANT

This form needs to be **completed only** if the Ministry of Social Development and Poverty Reduction will be covering the cost of your program. Inform your local office your need to enter Bridgeway's Recovery and Addiction treatment ***by taking this form to your Ministry office for completion*** and have it **faxed back to our office at 250-491-7331.**

Please sign the following consent form:

I, _____, hereby authorize the staff from the Ministry of Social
(Please print name)
Development & Poverty Reduction to obtain and release information from my file required to establish payment of user charges. This includes any income or assets received or pending, any missing documents that might affect my eligibility.

Signature: _____

SIN:_____ Date:_____

Anticipated date of entry into the program is: _____

TO: MINISTRY WORKER

The bearer of this letter has been referred to The Bridge Youth & Family Services, Bridgeway Recovery & Addiction Services (a qualified Recovery and Addictions program). Prior to admission, the facility requires confirmation that the applicant's per diem costs (less any non-exempt income) will be paid by the Ministry while in receipt of, and eligible for, income assistance.

Please indicate the following:

Does the client have an open and active MSD file? Yes ☐ No ☐ Client GA#:_____

Client is ☐ **ELIGIBLE or** ☐ **INELIGIBLE** for funding. (check only one box) **Pending E.I benefits**? Yes ☐ No ☐

APPLICATION FOR SERVICE REQUEST: SR#:_____

Is the client required to pay a monthly contribution to the facility? Yes ☐ No ☐ If yes, the amount of: $_____

If a monthly contribution applies, it will be taken out of the clients?: CPP ☐ EI ☐ CPPD ☐ Other ☐

If other, please indicate where:_____

Worker Signature:	Worker Comments:	**Ministry Office Stamp**:
Worker Name (please print):		
Date:		

EARLY EXIT TRANSITION PLAN

The following plan will be put in place if I leave early from Bridgeway. I understand that as I continue treatment staff will assist me to develop a more complete transition plan to ensure my continued support and recovery when returning home.

It is understood that if I leave the program early my referral and my emergency contact will be notified immediately.

Destination upon early exit:
How will I get there?
In case of early exit, be aware that it may take several days to arrange travel from The Ministry of Social Development and Poverty Reduction. Please ensure that alternate travel arrangements can be arranged immediately if necessary.

COMMUNITY CONTACT FOR EARLY EXIT SUPPORT

Name:	Telephone:
Organization:	

CRISIS PLANNING PROCEDURES

The following plan will be implemented should my mental health status become critical, I will:

PARTICIPATION AGREEMENT

I have agreed to apply for treatment at Bridgeway Recovery & Addiction Services and have reviewed the program services available. I understand that Bridgeway is an abstinence-based program and I agree with the following:

- ☐ I will participate in the following activities upon arrival to Bridgeway and commit to the 42 day treatment program:
- ☐ I will provide urine drug screens and breathalysers upon admission and when requested by staff.
- ☐ Participate in a medication review.
- ☐ Will treat others with respect, dignity and without discrimination.
- ☐ Participate in an assessment and development of a treatment plan and follow this treatment plan.
- ☐ Participate in group and individual counselling programs.
- ☐ Will adhere to the restriction guidelines including remaining on property unless unaccompanied by staff.
- ☐ Will wear a face mask as directed by staff.
- ☐ Will work with Bridgeway staff in order to plan a successful return home after treatment.
- ☐ Follow program guidelines including no violence and no recruitment of others into gangs or prostitution.
- ☐ Will abstain from all drugs and alcohol except medication prescribed by a physician during my treatment (we are not able to accommodate medical marijuana prescriptions).
- ☐ Will not use scents during my treatment.
- ☐ Will keep all information about other program participants confidential.
- ☐ Will provide all prescription and non-prescription medications to the staff.
- ☐ Will share a room during my stay and will keep it clean and clutter free.
- ☐ Will not have or store any food items in my room or other non-designated areas of the centre.
- ☐ Will not have individuals in my room except for staff.
- ☐ Staff may conduct random room searches in my room throughout my stay at the centre.
- ☐ Will take all my belonging upon discharge. Belongings left after discharge from the centre will be donated to charity.
- ☐ Will smoke/vape in designated smoking area only.
- ☐ Refunds are made only if the client leaves Bridgeway Recovery & Addiction Services within the first week (7 days). Refund is 50% of the full fee, payable only to the person/organization that paid the fee. Fees are non-refundable after the first week

SIGNATURES

Applicant:	Date:
Referral Agent:	Date:

PRE-ADMISSION CHECKLIST

Bridgeway Recovery & Addiction Services is located at 265 Gray Road in Kelowna. We are directly behind the Plaza 33 Shopping Centre that is located on Highway 33 West.

Please be sure to arrive at your scheduled time or call us at 1-855-760-0456 ext. 2402 to make other arrangements.

Please bring the following items:

Toiletries; shampoo, soap, toothpaste etc.

Running shoes and suitable clothing for recreation/swimming. Reduced YMCA passes are available to our participants. A gym bag and gym towel is recommended.

Face cloth if needed.

Appropriate clothing for the season; please no clothing with drug or alcohol advertising, no racial, sexist, gang emblems or designs.

Cell phones, IPods, laptops etc. are acceptable.

Refillable water bottle &/or travel mug is useful.

Participants may bring a vehicle but should be aware that parking is on street only.

A telephone is available for local calls and where messages can be left for you from outside callers. Calling cards are recommended for personal long distance calls.

Please <u>do not</u> bring the following items:

Large sums of money ($25.00/week should be sufficient) Reminder, you are sharing your space so please leave valuables at home.

Small safes are provided in each bedroom for each participant.

Cameras and/or video cameras.

Any perishable food items.

More than 2 pieces of luggage as space is limited.

VOLUNTARY CONSENT FOR RELEASE OF INFORMATION

Bridgeway maintains strict personal confidence rules and we will not share information about you without your written consent nor will Bridgeway confirm or deny that you are here. We do however; need to speak to certain person(s) or agencies for the purpose of obtaining or providing information that will be helpful to your treatment plans.

I do therefore give permission for Bridgeway personnel to exchange relevant information with accessed services, facilities and person(s) during my time in the program; this would include but is not limited to my referral source, local medical facilities, the Shoppers Drug Mart, the Kelowna Wellness Centre and my emergency contact person.

Please consider and add any additional people not previously mentioned such as your physician(s), social worker, and counselor and/or family members.

Name	**Relationship to applicant**	**Phone number**	**Initials**

I, _____, consent for Bridgeway Recovery & Addiction Services
(Please print applicant's name)

to receive, release and exchange information with any and all person/agencies listed on this referral.

_____
Applicant Signature

I, _____, **have reviewed the provided information and am supportive of**
(Referral Agent, please print)

this application and believe this applicant to be an appropriate fit for Bridgeway.

_____ _____
Referral Signature **Date**