Beacon Program

Empowering individuals to make choices, to grow, and to find a more satisfying life.

Referral Package

Program Description

Beacon is a voluntary community-based Psychosocial Rehabilitation (PSR) program for young adults living with mental illness.
A six-bed residence, Beacon accommodates applicants from across the province, with a typical stay of six months. Our goal is to help individuals work toward increasing their capacity to achieve success and satisfaction in their living, learning, working and social environment. Part of our focus is to develop skills and enhance involvement with the community. We work with the referral agency throughout admission to support clients in returning to their home communities.

Admission criteria

- Between age 18 and 35
- Cognitive functioning which would allow individuals to function in a daily educational environment
- Stable in their illness (not necessarily symptom free)
- A resident of Nova Scotia
- Diagnosed with (incl. provisional diagnosis):
    - Schizophrenia
    - Bipolar Disorder
    - Psychosis NOS
    - Schizoaffective Disorder

** Admission eligibility is not necessarily affected by additional diagnoses, including substance use disorder.*

** We serve a wide variety of individuals. If you are unsure if a diagnosis meets our criteria please call us.*

Referral process

- A tour of the house by the prospective client is recommended and encouraged prior to completion of the referral package. A tour can be arranged by contacting Elizabeth van Roestel at (902) 678-8363 or by email.

- The following package is designed to help determine if a referral is appropriate for the program. For more information please see the website (www.beaconprogram.ca).

- Submission of a referral form that has been thoroughly completed will expedite the referral process. Referral forms will be processed once all of the required information has been received.

- The completed information will be reviewed by the Beacon Team, after which the referring agency will be contacted regarding a potential interview with the referred individual.

Please ensure:

[ ] Applicant has signed Referral Form and Endorsement.
[ ] Referral Form is complete
[ ] Attending Psychiatrist has signed Referral Form.

Include Reports indicating:

[ ] diagnosis
[ ] medication history
[ ] level of functioning
[ ] medical history
[ ] substance use
[ ] cognition
[ ] Probation Order
[ ] C.T.O.
[ ] risk assessment (incl. SRA and violence)
[ ] Any other relevant documentation as it pertains to client functioning and care.

Once accepted to the program the following must be arranged:

- The Beacon Medical Form must be completed and a current health card number provided.

- Funding for a monthly $90.00 bus pass must be secured by the referring agency and or applicant prior to admission to the program. The purpose of the bus pass is to provide transportation using the local transit system from Beacon House (Kentville) to Changing Tides Day Program located in Berwick.

- Funding for medications must be arranged. If applicant has no medication coverage, please include a copy of the applicant's application for coverage (Pharmacare, etc).

- We will work with you to develop a discharge plan, both for scheduled discharge and for an unexpected early discharge. This will include transportation, shelter and support for the client.

- An outcome measure pretest (LOFS) must be completed and forwarded to Beacon by the applicant's current health care team. (This will also be requested as a follow-up outcome measure 6 months post-discharge.)

GENERAL INFORMATION:

Name of Applicant: _____ Age: _____

DOB: _____/_____/_____ Health Card #: _____Exp. Date:_____

D M Y

Current Living Address: _____

_____

Current Phone Number: _____

Street Address of *Usual* Place of Residence: _____

_____

Mailing Address of *Usual* Place of Residence (if different from above): _____

_____

Name of Next of Kin: _____

Relationship to applicant:_____

_____

Address: _____

_____

Current Phone Number: _____

Street Address of *Usual* Place of Residence: _____

_____

Mailing Address of *Usual* Place of Residence (if different from above): _____

_____

Referred by: _____ Telephone #: _____

Relationship to applicant:_____

Email address: _____ Fax #: _____

Mailing Address: _____

Individual's primary contact person/worker, if different than referring agent:

Name: Phone:

PSYCHIATRIC INFORMATION

Name of Psychiatrist: _____ Telephone #: _____

Email Address: _____ Fax #: _____

Date of last visit to Psychiatrist: ____/____/____

Diagnosis: _____

_____

History of Presenting Problem (including age of onset of mental illness): _____

_____

_____

_____

Current Mental Status: _____

_____

_____

Reason for Referral: _____

_____

_____

Previous psychiatric admissions and discharges

Admission Date	Discharge Date	Facility

Applicant's understanding of his/her diagnosis: _____

_____

_____

_____

_____

Applicant's understanding/acceptance of the need for treatment and medication _____

_____

_____

Other relevant psychiatric information: _____

MEDICAL INFORMATION (*Please be aware that Beacon Program does not have a resident GP. Clients may access local clinics, or their own community family doctor.)*

Name of GP: _____ Telephone #: _____

Email Address: _____ Fax #: _____

Address: _____

Present Medical Condition(s) and/or treatment(s) (Please note if these are currently stable/self-managed): _____

Relevant Medical History: _____

SUICIDE/SELF-HARM/AGGRESSION

History of suicidal behaviour: (specific details of behaviours, timelines, current status, etc)

Thoughts/ideation: _____

_____

Actions/behaviours: _____

_____

_____

History of self-harm behaviour: _____

_____

_____

_____

History of aggressive or violent behaviour (details): _____

_____

_____

_____

Please include most recent risk assessment

MEDICATIONS

Is the client generally successful in taking his/her own medications? Y / N

If no, please explain. _____

_____

_____

What are the client's thoughts about taking medications? _____

_____

_____

_____

Is the current treatment team satisfied that the client is receiving the maximum benefit from medications prescribed? If medication changes are required, please outline detailed plan describing medication changes. _____

_____

What medication delivery system (dosette, blister pack, bottles, etc) does the applicant use:____

_____

List ALL Present Medications

Name	Dose	Frequency	Time Taken

If on I.M depot, date of last injection:_____Frequency of I.M.:_____

If monitoring required (lithium, clozapine) include last report.

Medication coverage (e.g. private health plan, Pharmacare, exemption status): _____

Client's current pharmacy: _____

Pharmacy address: _____

Pharmacy phone number: _____

SUBSTANCE USE / GAMBLING

Does the applicant use drugs, alcohol, tobacco or gamble? YES / NO

Substance	Frequency	Amount	Last Use	Impact

What are the impacts of substance use/gambling? _____

What treatment interventions have been accessed/are currently being accessed? (Addictions Services, A.A., N.A., G.A., etc) Provide details **incl. contact info**:_____

LEGAL HISTORY

Has the applicant had involvement with the legal/justice system in the past 5 years? Yes / No

If yes, please explain. _____

_____

_____

_____

Name/# of Probation worker: _____ Next court date: _____

Other relevant legal Information: _____

Provide copy of CTO **Provide copy of probation order**

USUAL LIVING SITUATION

Housing situation: _____

_____

Coinhabitants: _____

_____

Pets: _____

In the opinion of the referring agency, is this housing stable, safe and healthy? _____

_____

_____

_____

FUNCTIONING:

Please comment on applicant's daily activities during the past month, including support required.

Living: experience with independent living (performance of self-care and household management tasks including dressing, bathing, meal preparation, budgeting, housekeeping, medication management, and ability to schedule and attend appointments): _____

_____

_____

_____

_____

_____

_____

Social: (relationships/family/friends): Quality of social relationships:

Barriers to social relationships:

Leisure Activities: (include active, passive, social, and solitary leisure activities):

Employment: Currently Works/Volunteers [ ] Has Worked/Volunteered in the past [ ]

Details:

Learning/Education: Highest level of education attained:

Other courses/:

Cognitive functioning incl. learning disabilities (please attach report if available):

Other relevant information (e.g. eating habits, sleeping habits, etc)

SUPPORTS AND RESOURCES

What resources is the applicant currently accessing?

Please include name, phone number and brief description of support.

[ ] Family: _____

_____

_____

[ ] Mental Health Clinic: _____

_____

_____

[ ] Community Mental Health Worker: _____

_____

_____

[ ] Other agencies related to living, learning, working or socializing: _____

_____

_____

_____

Source of income: (If Income Assistance name and number of IA worker):_____

_____

_____

Other Relevant Support/Resource Information: _____

_____

_____

_____

In addition to resources and supports the applicant is currently accessing he/she would benefit from the following support or resource in the areas of living, learning, working or social: _____

_____

_____

_____

_____

REFERRING AGENCY and PSYCHIATRIST ENDORSEMENT

It is understood that during the client's stay with Beacon, and at the end of the six month admission period, Beacon will provide us with specific information regarding suitable housing and necessary supports for the client to return to the community.

We will collaborate with Beacon to ensure that housing is in place at time of discharge. We recognize that we will resume care and responsibility for the resident upon discharge.

In the event that a client demonstrates an inability or unwillingness to participate in the Beacon Program, Beacon may discharge the client. Beacon will collaborate with the referring service to facilitate a smooth transition.

I endorse this referral on behalf of _____.
(Referring agency**)**

_____ _____
(Signature of referring individual) (Date)

_____ _____
(Signature of referring psychiatrist) (Date)

APPLICANT ENDORSEMENT

What are your thoughts on coming to Beacon? Why do you want to come to Beacon? What do you hope to gain? What are your hopes, goals, etc?

(Signature of applicant) (Date)

This section for Beacon use only:

Date of receipt of completed referral Staff Initials