Aftercare Information Form

St. Michael's Homes Aftercare Program offers post-treatment supports through telephone check-ins, general counselling, and peer group support, in an effort to complement your recovery goals. The Aftercare Program is available to you upon completion of treatment, and at any point of your recovery. Please complete this form with staff so that we have the information we need to successfully contact you after your departure from treatment.

TODAY'S DATE:

1. **Client's First & Last Name:**
2. ***Client's Birth Date (dd/mm/yyyy):**
3. **What is your preferred method of contact?** Phone ☐ Email ☐ Both ☐

   a. Client Phone Number:

   Can a voicemail be left for you at this number? Yes ☐ *No* ☐

   Can texts be sent to you at this number? Yes ☐ *No* ☐

   What time of day do you prefer to be contacted?

   Morning ☐ *Afternoon* ☐ *Evening* ☐

   b. Client Email:

   Can emails be sent regarding the following:

   General check-in? Yes ☐ *No* ☐

   Events Only? Yes ☐ *No* ☐
4. ***Expected Discharge Date (dd/mm/yyyy):**
5. **Address After Treatment:** _____

   _____

   _____
6. **Do you have an emergency contact?** Yes ☐ No ☐

   We might call this person if we are concerned for your safety, have reason to believe you might be at risk of self-harm or of harming someone else, or have lost contact with you when you are in a situation that puts you at risk of harm.

   Name: Phone Number:

7. **Are you working with any other supports for your recovery?** Yes ☐ No ☐

   Name of the support person:

   Contact Number:

   Agency/Institution Details:

8. **What is your recovery goal?**

   Abstinence ☐ Harm Reduction ☐

9. **What <u>recovery group</u> would you feel most comfortable in?**

   Abstinence ☐ Harm Reduction ☐ Mixed ☐

10. **What interests you in joining the Peer Support Program?** _____

    _____

    _____

11. **We all have our weaknesses and difficulties. What would support your successful participation in the peer support group?** _____

    _____

    _____

12. **What help do you think will be beneficial for you after you leave the Treatment/Housing Program?**

    ☐ Telephone check-in/counselling

    ☐ Crisis intervention

    ☐ Peer Support Groups

    ☐ Solution-Focused Brief Therapy

    Notes:

_____

_____

**Note: please ensure that the client is aware that email will not be used to communicate information beyond setting an appointment time. No personal health information will be communicated from our staff via email.

I _____ hereby authorize St. Michael's Homes staff to contact me to provide Aftercare Supports as outlined on this form. I understand that I can decide to discontinue supports at any time.

Client Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____