ALBERTA NNADAP

ADULT RESIDENTIAL TREATMENT REFERRAL FORM

This form is to be completed by the referring NNADAP Worker or other agent with the client.

Call your preferred treatment centre to inquire about bed availability PRIOR to submitting a referral form. Please refer to one treatment centre at a time.

The medical assessment must be completed by a physician.

PLEASE NOTE: **ALL SECTIONS MUST BE COMPLETED**. INCOMPLETE APPLICATIONS WILL BE RETURNED.

Select your preference for referral to **one** of the following Alberta NNADAP Adult Treatment Centres:

☐ Beaver Lake Wah-Pow Treatment Centre
Beaver Lake
(780) 623-2553 (Tel)
(780) 623-4076 (Fax)

☐ Mark Amy Treatment Centre
Fort McMurray
(780) 334-2398 (Tel)
(780) 334-2352 (Fax)
www.woodbuffalowellnesssociety.com

☐ Kapown Rehabilitation Centre
Grouard
(888) 751-3921 (Toll-free)
(780) 751-3921 (Tel)
(780) 751-3831 (Fax)
www.kapown.ca

☐ Footprints Healing Centre
Alexander
(780) 939-3544 (Tel)
(780) 939-3524 (Fax)

☐ Kainai Healing Lodge
Standoff
(403) 737-3757 (Tel)
(403) 737-2207 (Fax)

Treatment Centre Use Only:

Registration Date: (D/M/Y) ___/___/___

Admission Date: (D/M/Y) ___/___/___

Client File Number: _____

Cancellation Date: (D/M/Y) ___/___/___

PART 1 – CLIENT INFORMATION

Complete the following in the spaces provided. If any information is not applicable indicate as NA, unknown as UNK and unavailable as UNA.

A. General Information

Surname:		First Name:		Nickname (or other name known by):	
Date of Birth: D M Y		Age:	Gender: ☐ Male ☐ Female	Provincial Health Card Number:	
Address:					
Telephone:	Home:		Cell:	Other:	
Language(s):	Spoken:		Understood:	Preferred:	
Status Indian?	☐ Yes ☐ No	Band Name:		Treaty #:	
Emergency Contact:		Telephone:		Relationship:	
Employment Status:					
Education Status:		Last grade/educational program completed:			
Literacy Level					

FAMILY RELATIONSHIPS

Marital Status:	☐ Single	☐ Married	☐ Common-Law	☐ Widowed	☐ Separated	☐ Divorced
Does client have dependent children?	☐ Yes ☐ No	If yes, do they have access to adequate childcare while in treatment?			☐ Yes ☐ No ☐ Not applicable	
Are any of the children in care?	☐ Yes ☐ No ☐ Not applicable	If yes, please describe:		Child Welfare Service Plan attached ☐ Yes ☐ No ☐ Not applicable		
Does the client have other dependents?	☐ Yes ☐ No	Please provide information on client's children or other dependents in the section below:				

Child/Dependent's Name	Gender:	Age	Relationship
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		

Family Supports:	
Family Strengths	

LEGAL STATUS

Has client been court ordered to attend treatment? ☐ Yes ☐ No	Probation Order attached? ☐ Yes ☐ No
Is the client under any of the following legal conditions? ☐ Bail ☐ Parole ☐ Temporary Absence Order ☐ Other (provide details, dates, etc.)	

TREATMENT HISTORY

Has client participated in a non-residential community-based substance abuse and/or mental health program? ☐ Yes ☐ No				
If yes, describe program(s):				
Is client currently prescribed:				
Methadone ☐ Yes ☐ No			Suboxone ☐ Yes ☐ No	
If yes, who is the prescribing physician?			Length of time on medication:	
Other relevant information related to this medication				
Has client participated in a residential treatment program before? ☐ Yes ☐ No				
If yes, please provide information on previous treatment experiences:				
Year	**Treatment Centre**	**Type of Addiction**	**Completed**	**Comments**
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
Describe client's reason(s) for currently requesting treatment:				

B. Substance Use Profile

SUBSTANCE Circle specific substance(s) or print name	**Pattern & Frequency of Use** In last 6 months: Occasional, Daily, Weekly, Monthly, Binge, Other	**Method of Use** N = nasal/snort O = oral/swallow IV = inject IS = inhale/smoke	**Average Amount Used** In a 24-hour period)	**Length of Time Used** In days, months, years	**Date Last Used** Include time if known
Alcohol: E.g. beer, wine, coolers, liquor, homebrew, Lysol®, hairspray, mouthwash, aftershave, etc.					
Marijuana: E.g., pot, hash, hash oil, etc.					
Cocaine: E.g. Crack, powder					
Inhalants/Solvents: E.g. Lacquer, glue, paint thinner, gasoline, aerosol sprays, amyl nitrate, etc.					
Club Drugs: E.g. Ecstasy (MDMA), GHB, Rohypnol, Ketamine, etc.					
Hallucinogens: E.g. Psilocybin mushrooms, LSD, Peyote, PCP (Angel Dust), Mescaline, DMT					
Amphetamines: E.g. Crystal meth, speed					
Illicit Street Opiates: E.g. Heroin, Opium					
Fentanyl Illicit Fentanyl or prescription, e.g. Duragesic®, Sublimaze®, Actiq®					
Prescription Opioids: E.g. Codeine (T-2s, T-3s,) Oxycodone (Percodan®, Percocet®), Hydrocodone (Lortab®, Lorcet®) Dilaudid®, Darvon®, Morphine, Demerol®, etc.					
Prescription Sedatives, Tranquilizers, Barbiturates, Benzodiazepines E.g. Valium®, Ativan®, Serax®, Rivotril®, Halcion®, Librium®, Xanax®, Mogodon®, Nembutal®, Luminal®, Ambien®, etc.					
Prescription Stimulants: E.g. Ritalin®, Dexedrine®, Adderall®, Concerta®, etc.					
Gabapentin (Neuronton®)					
Over the Counter Drugs: E.g. Codeine (T-1s), Gravol®, Cough Syrup with Dextramethorphan (DXM) etc.					
Anabolic Steroids					

Substance(s) of choice: 1. _____ 2. _____ 3. _____

C. Withdrawal Symptoms

Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptom			Describe
Blackouts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Hallucinations	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Nausea/vomiting	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Seizures	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Shakes	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Delirium Tremens (DTs)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Blackouts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	

D. Process/Behavioural Addictions

Has client experienced problems with any of the following?

Process/Behavioural Addiction			Describe
Gambling (slots, cards, Keno, bingo etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Sex (promiscuity, etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Internet, texting	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Other	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Other	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Other	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	

E. Mental Health Issues

Provide the following information about the client's mental health status:

Mental Illness			Description
Been diagnosed with mental illness(es)	☐ Yes ☐ No	☐ Unknown	If yes, is medical documentation attached? ☐ Yes ☐ No ☐ Not applicable
Currently being treated for mental illness(es)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, what treatment is being provided and by whom?
Currently on psychiatric medication	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, describe medication.
Taking medication consistently	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	Please describe.
Previous suicide attempts?	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, when? Please describe.
Hospitalized for suicide attempts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, when? Please describe.
Currently suicidal	☐ Yes ☐ No	☐ Unknown	If yes, for how long? Please describe.

F. Other Issues/Needs

Provide information about other client issues and needs:

Describe client's cultural and/or spiritual beliefs and practices that we need to be aware of.
Describe client's personal strengths:
Describe other significant issues we need to be aware of.

G. Application Checklist

Confirmation of transportation to Treatment Centre through referral	☐ Yes ☐ No
Confirmation of transportation back home	☐ Yes ☐ No
Client has been notified that transportation to return to the community will not be provided for clients who discharge themselves from treatment, against advice from the treatment centre counsellor, before completing the program. Exceptions may be considered for clients who are minors or in cases when proper justification is provided and approved by the NIHB Regional Office. In Alberta, the NIHB Regional Office conducts reviews on a case-by-case basis and may provide services should a client choose to self-terminate treatment.	☐ Yes ☐ No
Client understands there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment.	☐ Yes ☐ No
Client understands there is an expectation to be alcohol and drug free for at least 7 days prior to admission to residential treatment (or 14 days if withdrawing from benzodiazepines). (*Clients with less than the required days must notify the treatment centre prior to admission).*	☐ Yes ☐ No
Client understands there is an expectation of completion of a minimum of four aftercare counselling sessions upon completion of residential treatment.	☐ Yes ☐ No

Client has been informed about the following personal items needed on entering treatment:

- ☐ Toiletries (toothbrush, toothpaste, shampoo, deodorant, etc.)
- ☐ Bathing suit and shorts
- ☐ Warm clothing (boots, coat, hat, gloves, etc.)
- ☐ 2 pairs of running shoes for indoor/outdoor activities
- ☐ Towel and facecloths
- ☐ Pajamas and slippers
- ☐ Personal items (e.g. feminine hygiene products)
- ☐ Medications (All non-prescription and physician prescribed medication MUST be handed in to intake worker upon arrival and must be in SEALED, ORIGINAL PACKAGING)
- ☐ Tobacco/nicotine replacement products
- ☐ Money
- ☐ Valid identification card
- ☐ Provincial health card(s) or photocopy of health card

Client Authorization

I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by the Treatment Centre.

Client Signature

Date (D/M/Y)

Referral Signature

Date (D/M/Y)

PART 2 – REFERRAL INFORMATION

Referral Worker Name: _____ Title: _____

Agency: _____ Telephone: _____

Fax: _____ Email: _____

Address: _____

Has the client completed four pre-treatment appointments? ☐ Yes ☐ No

Please provide dates of completed pre-treatment appointments (D/M/Y):

1. _____ 2. _____ 3. _____ 4. _____

Will you continue to see the client once he/she has completed treatment? ☐ Yes ☐ No

If no, please explain:

What other supports would be available to your client in their community upon completion of treatment?

Name/Resource	**Description of Support**

Briefly summarize all assessment processes completed with the client (e.g. CAGE MAST, DAST, Treatment Readiness, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, social, psychological, spiritual, emotional). Include scoring and interpretations. Attach a separate sheet if necessary or the assessment summary from your client file.

Client's Stage of Readiness

- ☐ Pre-contemplation - Not considering change; resistant to change
- ☐ Contemplation - Unsure of whether or not to change; chronic indecision
- ☐ Determination - Preparation; committed to changing behavior within one month
- ☐ Action – Begin changing behaviour
- ☐ Maintenance - Behaviour change has persisted for 6 months or more

Please list any questions or concerns the client has indicated during the intake process.

What other areas might need to be addressed in treatment? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.)

Referral Agent assessment of client's strengths and potential challenges for completing treatment.

Referral Checklist

Please initial which applicable items have been completed. Check off any items attached to this application:

Item	Attached	Initials
Psychiatric evaluations	☐	
Probation order	☐	
Current Medical Assessment form	☐	
Assessment Summary	☐	
Substance Abuse Profile	☐	

Please initial each item that has been completed:

Item	Initials
Confirmation of transportation to the treatment centre	
Confirmation of transportation back home after completion of treatment	
All medical, dental and optical appointments have been dealt with prior to treatment.	
All financial matters have been dealt with prior to treatment.	
All legal matters have been dealt with prior to treatment.	

Referral Signature

Date (D/M/Y)

PART 3 – MEDICAL ASSESSMENT

Note: This form may be substituted with the medical assessment in the Alberta Health Services Residential Adult Addiction Treatment Program Application form (pp. 7-9) http://www.albertahealthservices.ca/frm-18020.pdf

All clients must have this form completed by a physician. Please note: **First Nations Inuit Health - Alberta Region - Non-Insured Health Benefits** covers a **maximum of $60.25 for a medical assessment by physicians in Alberta.** The invoice has to include the client's treaty number and confirmation that the invoice is a medical assessment. Please send the invoice directly to: **Regional NNADAP Treatment Referral Client Coordinator: Suite 730, 9700 Jasper Avenue, Edmonton AB, T5J 4C3. Faxes will not be honored.** ***In order to protect client confidentiality please do not attach this assessment to the invoice.***

Applicant's name: _____ Health Care Number:

Treaty Number (10 digits) _____ Are you the client's regular physician? ☐ Yes ☐ No

A. Medical History: (explain any 'yes' responses in Section B)

	Diagnosed		Tested		Comments
	Yes	**No**	**Yes**	**No**	
Central Nervous System Disorder	☐	☐	☐	☐	
Chronic bronchitis	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Heart problems Current blood pressure _____	☐	☐	☐	☐	
Gastrointestinal problems	☐	☐	☐	☐	
Pancreatic problems	☐	☐	☐	☐	
Kidney or urinary problems	☐	☐	☐	☐	
Diabetes / hypoglycemia	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
Chronic pain	☐	☐	☐	☐	
Eating disorders	☐	☐	☐	☐	
Sleep disorders	☐	☐	☐	☐	
Withdrawal symptoms, seizures, etc.	☐	☐	☐	☐	
Mood disorders (e.g., major depressive disorder)	☐	☐	☐	☐	
Psychotic disorders (e.g., schizophrenia)	☐	☐	☐	☐	
Personality Disorders	☐	☐	☐	☐	
Liver problems: Hepatitis B & C	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
Sexually Transmitted Diseases	☐	☐	☐	☐	
Medical confirmation of pregnancy	☐	☐	☐	☐	____ weeks
Allergies	☐	☐	☐	☐	

Any other medical problems not listed:

B. Are there any specific problems that should be considered in the treatment of this applicant?

C. Current Medications

Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. Please note no mood altering medications will be allowed in residential treatment unless prescribed and monitored by a psychiatrist for management of a mental illness.

DRUG NAME	DOSE/SCHEDULE	LENGTH OF TIME USED	CLINICAL INDICATION

Reminder to physician: For the applicant's safety and wellness while in residential treatment, please arrange with his or her pharmacy for compliance with packaging of medication to take to treatment and prescribe sufficient quantities for duration of treatment.

Is the applicant stabilized on medication? ☐ Yes ☐ No

In the past 6 months has the client been using the medication appropriately? ☐ Yes ☐ No

If no, please explain:

Physician's Name: Telephone:

Date: Address:

PRAC ID: Fax:

Physician's Signature: Date:

Physician's Stamp: