

APPLICATION TO RESIDENTIAL TREATMENT

Select your preference for referral to one of the following Treatment Centres:

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Beaver Lake Wah-Pow Treatment Centre
Beaver Lake
(780) 623-2553 (Tel)
(780) 623-4076 (Fax)
www.blwt.com | <input type="checkbox"/> Mark Amy Treatment Centre
Fort McMurray
(780) 334-2398 (Tel)
(780) 334-2358 (Fax)
www.markamytreatmentcentre.com | <input type="checkbox"/> Kapown Rehabilitation Centre
Grouard
(888) 751-3921 (Toll-free)
(780) 751-3921 (Tel)
(780) 751-3831 (Fax)
www.kapown.ca |
| <input type="checkbox"/> Footprints Healing Centre
Alexander
(780) 939-3544 (Tel)
(780) 939-3524 (Fax) | <input type="checkbox"/> 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) ___/___/___

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED.
 INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS.**

Form to be completed by referring agent.
 If any information is not applicable indicate as NA, unknown as UNK and unavailable as UNA.
 Attach a separate sheet of paper if more room is needed.

PART 1 – CLIENT APPLICATION

A. General Information

Complete the following in the spaces provided.

Surname: _____	Healthcare Number: _____
First Name(s): _____	Address (Home): _____
Nickname or other name known by: _____	City: _____
Date of birth: (D/M/Y) ___/___/___	Province: _____
Age: _____	Postal Code: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Telephone(s): _____
Languages: Spoken _____	
Preferred _____	
Understood _____	Emergency Contact
Status Indian: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____
Band Name: _____	Telephone(s): _____
Treaty Number (10 digit): _____	Relationship: _____

Children/Dependants

Does client have dependent children? Yes No

If yes, do they have access to adequate childcare while in treatment? Yes No

Are the children in care? Yes No Does the client have other dependants? Yes No

Provide information on client's children or other dependants:

Name	Age	Relationship

Legal Status

Has client been court ordered to attend treatment? Yes No

If yes, provide details (include details/copy of Probation Order if applicable and/or available):

Is the client under any of the following legal conditions? Bail Parole Temporary Absence Order

Other (provide details, dates, etc.) _____

Education

Last grade/educational program completed: _____

Treatment History

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
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Reason(s) for currently requesting treatment: _____

B. Substance Abuse 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 months, years	Date Last Used Include time if known
Alcohol: beer, wine, coolers, liquor, homebrew; Lysol, hairspray, mouthwash, aftershave					
Marijuana: Pot, hash, hash oil					
Cocaine: Crack, powder					
Inhalants: Lacquer, glue, paint thinner, gasoline, aerosol sprays					
Club Drugs: Ecstasy (MDMA), GHB, Rohypnol, Ketamine					
Hallucinogens: Mushrooms, LSD, Peyote, Angel Dust (PCP)					
Amphetamines: Crystal meth, speed					
Illicit Street Opiates: Heroin, Opium					
Prescription Opioids: Codeine (T-2s, T-3s), Oxycontin, Dilaudid, Percocet, Darvon, Morphine, Demerol					
Prescription Depressants: Diazepam (Valium), Lorazepam (Ativan), Serax, Rivotril, Halcion, Librium, Xanax, Barbiturates					
Prescription Stimulants: Ritalin, Dexedrine, Adderall					
Over the Counter Drugs: Codeine (T-1s), Gravol, Cough Syrup					

* Substance Abuse Profiles completed within 6 weeks prior to referral may be substituted and attached to this application form.

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	Yes	No	NA/UNK	Describe
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Delirium Tremens (DTs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ever experienced?

D. Process/Behavioural Addictions

Has client experienced problems with any of the following?

Process/Behavioural Addiction	Yes	No	NA/UNK	Describe
Gambling (slots, cards, Keno, bingo etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating (obesity, anorexia, bulimia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sex (promiscuity, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Internet, texting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

E. Mental Health Issues

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

Mental Illness	Yes	No	NA/UNK	Describe
Been diagnosed with a mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Currently being treated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Currently on psychiatric medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Taking medication consistently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Previous suicide attempts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when?
Hospitalized for suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when?
Currently suicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Name of psychiatrist/psychologist (if applicable): _____

F. Other Issues/Needs

Does client have cultural and/or spiritual beliefs and practices we need to be aware of? Please describe:

Does client have any literacy or learning needs or issues we need to be aware of? Please describe:

Are there any other significant issues we need to be aware of? _____

Does client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment? _____

Does client understand there is an expectation they have been 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).* _____

G. Application Checklist

- Confirmation of transportation to Treatment Centre through referral
- Confirmation of transportation back home
- Client has been notified and understands the Non-Insured Health Benefits policy change whereby anytime during treatment and the client self-terminates, or the Treatment Centre terminates the client, and medical transportation benefits have been provided, the client will have to assume the costs of the next trip to access medically required health services and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada.

Items needed:

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> Toiletries (toothbrush, toothpaste, shampoo, deodorant, etc.) <input type="checkbox"/> Bathing suit and shorts <input type="checkbox"/> Warm clothing (boots, coat, hat, gloves, etc.) <input type="checkbox"/> 2 pairs of running shoes for indoor/outdoor activities <input type="checkbox"/> Towel and facecloths <input type="checkbox"/> Pajamas and slippers <input type="checkbox"/> Personal items (e.g. feminine hygiene products) | <ul style="list-style-type: none"> <input type="checkbox"/> Medications (All non-prescription and physician prescribed medication MUST be handed in to intake worker upon arrival and must be in SEALED, ORIGINAL PACKAGING). <input type="checkbox"/> Tobacco products <input type="checkbox"/> Money <input type="checkbox"/> Valid identification card <input type="checkbox"/> 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

Referral Signature

Date

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

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 Checklist

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

Item	Attached	Initials
Psychiatric evaluations	<input type="checkbox"/>	
Probation order	<input type="checkbox"/>	
Current Medical Assessment form	<input type="checkbox"/>	
Assessment Summary	<input type="checkbox"/>	
Substance Abuse Profile	<input type="checkbox"/>	

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)

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

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 Signature: _____

Date: _____

Physician's Stamp: