VIRTUAL TREATMENT APPLICATION

PART 1 – CLIENT INFORMATION

A. GENERAL INFORMATION

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

Surname:	First Name:	Nickname:
Date of Birth: (Y/M/D) Age:	Gender Identity: ☐ Male ☐ Female ☐ Two-Spirit ☐ Other	
Address:		**Provincial Health Card #:**
Home Telephone:	Cell:	Email:
Language(s) Spoken:	Language(s) Understood:	Language(s) Preferred:
Status Indian? ☐ Yes ☐ No Band Name:		**10 Digit Treaty #:**
Emergency Contact Name:	Telephone:	Relationship to client:
Employment Status: ☐ Employed full-time ☐ Employed part-time ☐ Unemployed		Mandated by employer to attend treatment? ☐ Yes ☐ No
DOES THE CLIENT HAVE ACCESS TO THEIR OWN DEVICE? (PC, TABLET, PHONE) ☐ YES ☐ NO		
DOES THE CLIENT HAVE ACCESS TO A RELIABLE INTERNET CONNECTION? ☐ YES ☐ NO		**IF NO, DO THEY HAVE CELL SERVICE WHERE THEY RESIDE? ☐ YES ☐ NO**

Last grade/educational program completed:

Has the client been diagnosed with any learning problems/disabilities? ☐ Yes ☐ No If yes, please describe:

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 that enables them to attend treatment online 3-5 hours per day? ☐ Yes ☐ No

Are any of the children in care? ☐ Yes ☐ No ☐ Not applicable If yes, please describe:

Describe any current Child & Family Services involvement. As a child, did this client have involvement with Child & Family Services? Please describe.

Children Services 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 to Client
	☐ Male ☐ Female ☐ Other		
	☐ Male ☐ Female ☐ Other		
	☐ Male ☐ Female ☐ Other		
	☐ Male ☐ Female ☐ Other		
	☐ Male ☐ Female ☐ Other		
	☐ Male ☐ Female ☐ Other		

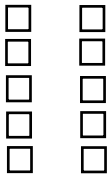
Who in the family and/or community is supportive of the client?

What does the client feel are the strengths of his/her family?

Legal Status

Has client been court ordered to attend treatment? ☐ Yes ☐ No	Probation Order/Parole Conditions attached? ☐ Yes ☐ No

Is client currently incarcerated? ☐ Yes ☐ No If yes, please explain:



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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
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, pint					
Illicit Street Opiates: E.g. Heroin, Opium					
Fentanyl & Analogues					
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.

D. 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	

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Symptom			Describe
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	

E. PROCESS/BEHAVIOURAL ADDICTIONS

Has the 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	

F. 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.

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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.

G. 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.

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H. APPLICATION CHECKLIST

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).	☐ Yes ☐ No
Client understands there is an expectation of completion of a minimum of four aftercare counselling sessions upon completion of virtual treatment.	☐ Yes ☐ No
Client has been informed of the following expectations for virtual treatment:	☐ Yes ☐ No

What to Expect During Virtual Treatment

- Expect to be treated fairly and without prejudice
- Confidentiality is of the utmost importance
- Monday to Friday, 9am-3pm - regular programming
- Minimum one individual counseling session per week, with ongoing support as required
- Daily ceremony
- Childcare needed for approximately 3-5 hours per day
- All necessary program materials will be shipped via Canada Post prior to treatment

What is Expected During Virtual Treatment

- Log in on time and complete all assignments by deadline
- Full attention and participation
- Regular, ongoing check-ins with NNADAP Referral Worker
- Must attend 3 additional events in each 7 day week (ex. NA, AA, etc.)
- Participation in daily, morning warm-up activity
- Each session should be attended privately to respect fellow client's anonymity

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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 (Y/M/D) _____

Referral Signature _____ Date (Y/M/D) _____

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PART 2 – REFERRAL INFORMATION

Exceptions for self-referral may be made, however a referral source is recommended and preferred. This is to ensure continuation of care, during and post treatment.

Referral Worker Name:		Title:	
Agency:		Telephone:	
Fax:		Email:	
Address:			

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

If no, please explain:

List supports and programs available to support recovery after your client leaves treatment (for aftercare planning).

Name/Resource	Description of Support

Briefly summarize all assessment processes completed with the client (e.g. CAGE, Audit, Socrates, 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 assessment scores 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

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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 (if requested)		
Self-Reported Medical History Form		
Assessment Summary		
Substance Abuse Profile		

Referral's Signature

Date (Y/M/D)

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PART 3 – SELF-REPORTED MEDICAL HISTORY

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.

This form may be completed by the client. If a physician, nurse practitioner, or registered nurse completes the form, please note that First Nations Inuit Health - Alberta Region-Non-Insured Health Benefits covers a maximum of $60.25 for a medical assessment by physicians in Alberta. Payment will depend on client attending treatment. The invoice must 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. To protect client confidentiality please do not attach this assessment to the invoice.

Applicant's name:		Health Care Number:	
Treaty Number (10 digits)		If completed by a physician, 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	☐	☐	☐	☐	
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	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	
Liver problems: Hepatitis B & C	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
Sexually Transmitted Infections	☐	☐	☐	☐	
Medical confirmation of pregnancy	☐	☐	☐	☐	# weeks
Is all related testing complete? ☐ Yes ☐ No	If no, please describe				
Are there any special considerations regarding the pregnancy and pre-natal care we need to be aware of?					
Current blood pressure:					

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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.
(Current computer printed attachment is acceptable.)

DRUG NAME	DOSE/SCHEDULE	LENGTH OF TIME USED	CONSISTENT USE?	CLINICAL INDICATION
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Are there prescription medications that the applicant runs out of before the prescription can be refilled? ☐ Yes ☐ No

Are there some prescriptions that the applicant outsources when their supply runs out? ☐ Yes ☐ No

Is the applicant stabilized on medication? ☐ Yes ☐ No

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

If no, please explain:

Physician's Name:	Telephone:
Date:	Fax#:
Address:	

Client Signature

Date (Y/M/D)

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