APPLICATION TO RESIDENTIAL TREATMENT

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

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

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

☐ St. Paul Treatment Centre
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: ________________________________

First Name(s): ________________________________

Nickname or other name known by: ____________

Date of birth: (D/M/Y) ___/___/___

Age: ______________

Gender: ☐ M ☐ F

Languages: Spoken ____________________

Preferred ____________________

Understood ____________________

Status Indian: ☐ Yes ☐ No

Band Name: ________________________________

Treaty Number (10 digit): ____________________

Healthcare Number: ____________________

Address (Home): ____________________

City: ________________________________

Province: ____________________

Postal Code:____________________

Telephone(s): ____________________

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Emergency Contact

Name: ____________________

Telephone(s): ____________________

______________________ 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
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ 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	☐	☐	☐	
Hallucinations	☐	☐	☐	
Nausea/vomiting	☐	☐	☐	
Seizures	☐	☐	☐	
Shakes	☐	☐	☐	
Delirium Tremens (DTs)	☐	☐	☐	☐ 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.)	☐	☐	☐	
Eating (obesity, anorexia, bulimia, etc.)	☐	☐	☐	
Sex (promiscuity, etc.)	☐	☐	☐	
Internet, texting	☐	☐	☐	
Other	☐	☐	☐	
Other	☐	☐	☐	
Other	☐	☐	☐	

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	☐	☐	☐	
Currently being treated	☐	☐	☐	
Currently on psychiatric medication	☐	☐	☐	
Taking medication consistently	☐	☐	☐	
Previous suicide attempts?	☐	☐	☐	If yes, when?
Hospitalized for suicide attempts	☐	☐	☐	If yes, when?
Currently suicidal	☐	☐	☐	

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:

- ☐ 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 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
Referral Signature	Date

PART 2 – REFERRAL INFORMATION

Name:______________________________ Title: ______________________________

Agency: ______________________________ Telephone: ______________________________

Address: ______________________________ Email: ______________________________

Fax #: ____

Has the client completed four pre-treatment appointments? ☐ Yes ☐ No
Please provide appointment dates:

(1)______________ (2)______________ (3)______________ (4)______________

Will you continue to see the client once he/she has completed treatment? ☐ Yes ☐ No
What other supports would be available to your client in their community upon completion of treatment?

Name/Resource	**Description of Support**

Please provide/attach a brief assessment summary*, including summarization of any assessment processes completed with the client (e.g. SASSI, MAST, DAST, 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).

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* Assessment Summaries completed within 6 weeks of this application may be substituted and attached.

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.)

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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)

CONDITION	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:

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

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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: ______________________

Date: ______________________

PRAC ID: ______________________

Telephone: ______________________

Address: ______________________

Fax: ______________________

Physician Signature: ______________________ Date: ______________________

Physician's Stamp: