



SAULTEAUX HEALING & WELLNESS CENTRE INC.

BOX 868 KAMSACK, SK S0A 1S0

Email: shwc.intake-reception@sasktel.net

Tel: 306-542-4110 website: www.shwc.ca FAX: 306-542-3241



ADULT INTAKE/REFERRAL APPLICATION

A. General Information											
Date Application Received by Community Worker		Date Application Received by Treatment Centre									
Surname:	First Name:	Nickname or other name known by:									
Date of Birth:	Age:	Sex:	Provincial Health Card Number:								
Address:			Telephone:								
Language Spoken:	Language Preferred:	Email:									
Emergency Contact Name:		Telephone:	Relationship:								
Status Indian:	Status Number: (10 digit status number)	Band Name:									
	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table>										
Education (last grade completed):	Literacy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs assistance	Employment Status:									
Family/Relationships											
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Common-Law Yes <input type="checkbox"/> Widowed											
Does Client have dependent children?		<input type="checkbox"/> Yes <input type="checkbox"/> No									
If yes, do they have access to adequate childcare while in treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not Applicable								
Are the children in care?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not Applicable								
Child Protection Worker Name:		Telephone:	Fax:								
Child and Family Agency:			Email:								
Provide information on client's children or other dependents:											
Name(s)	Age	Relationship									
Family Supports:											
Family Strengths:											

2020 PROGRAM DATES**MAY BE SUBJECT TO CHANGE**

INTAKE 027	January 8 – February 18, 2020	Deadline: Dec 11/ 2020
INTAKE 028	February 24 – April 3, 2020	Deadline: Feb 10/ 2020
INTAKE 029	April 8 – May 19, 2020	Deadline: Mar 24/ 2020
INTAKE 030	May 25 – July 3, 2020	Deadline: May 11/2020
INTAKE 031	August 6 – September 16, 2020	Deadline: Jun 26/ 2020
INTAKE 032	September 21 – October 30, 2020	Deadline: Sep 7/ 2020
INATEK 033	November 4 – December 15, 2020	Deadline: Oct 19/ 2020

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
Probation Order

Other (provide details, dates, etc.):

Treatment History

Has client participated in a non-residential/community based substance abuse program? Yes No

Has client participated in a non-residential/community based mental health program? Yes No

Has client participated in a residential treatment program before? Yes No

If yes, please provide information on previous treatment experience:

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:

Residential Schools: Did you or your family members attend Residential School? Yes No

Please Explain:

B. Withdrawal Symptoms

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

Symptom	Describe
Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown

Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Shakes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Delirium Tremens (DT's)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Ever experienced DTs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

C. Process/Behavioural Addictions

Has client experienced problems with any of the following?

Process/Behavioural Addiction		Describe
Gambling (slots, cards, Keno, bingo, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Eating (obesity, anorexia, bulimia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Sex (promiscuity, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Internet/texting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Affiliation: Are you Affiliated with Street gangs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

Part D: Medical Form
To be filled out by a Medical Practitioner

Last Name of Patient: _____ First Name of Patient: _____
Date of Birth: _____ Provincial Health Care Number: _____

Name of Medical Practitioner Please Include License Number: _____

Telephone number of Medical Practitioner: (____) _____ Fax:(____) _____

Please examine the patient and indicate the presence of the following conditions and illnesses; as well as, status of treatment **if applicable:**

Condition/illness/concerns/details	Yes	No	Currently Treated	Cleared?
Allergies				
Diabetes				
Epilepsy or seizure disorders				
Sexually Transmitted Infections				
Scabies				
Lice				
Cancer				
Stroke				
Tuberculosis				
Cardiovascular Disease				
Hepatitis A, B or C				
High Blood Pressure				
Emphysema or other Lung Disease				
Psychiatric concerns				
Diagnosed Mental Illness				
HIV/AIDS				
Gastrointestinal				
Hypothyroidism or Hyperthyroidism				
Pregnancy – DUE DATE: DD / MM / YYYY				
Back Pain				

Is this patient stable enough to attend a 6-week residential treatment program? Yes No

Does patient need medical detoxification before attending 6-week treatment program? Yes No

Is this patient taking any Narcotic, Opioid, Sedative or Hypnotic medication? Yes No

yes, is there an alternative non-narcotic medication? (Please list) _____

Is it safe for this patient to use a dry sauna while in treatment? Yes No

Special dietary requirements: _____

Are there any operations or serious illnesses within the past year that staff of the treatment facility need to be aware of?

Give approximate dates, names of physicians or surgeons and results of treatment: _____

Are you aware of any factors in this patient's life (medical history, etc.) that may pose a threat to other clients or staff? Yes No

If yes, please explain:

TB Screening: Symptoms and history	Yes	No	Currently Treated	If Yes, please comment:
<u>Presence of cough lasting more than 2 weeks</u>				
<u>Weight loss #lbs. length of time</u>				
<u>Night sweats</u>				
<u>Fever</u>				
<u>Fatigue</u>				
<u>Hemoptysis (blood in sputum)</u>				
<u>Recent or past exposure of TB</u>				
<u>Previous active TB and treatment</u>				
<u>Previous significant Mantoux results or Chest X-ray results</u>				
<u>Extensive Travel (or birth) in a country with high incidence of TB</u>				
<u>Other risk factors for infection (Living in an area with high incidence of TB, elderly, homeless, health care worker)</u>				
<u>Poor general health status and risk factors for progression of disease</u>				
ACTIONS **Please ensure the patient has at least 6 weeks of necessary prescribed medication bubble packed**				
<u>Further TB screening or assessment required (if "yes" please fax results to Sauteaux Healing & Wellness Centre, Inc.</u>				

Doctor/Medical Practitioner Signature: _____

Date: (Month day, year) _____

D. Mental Health Issues

Provide the following information about the clients health status:

Mental Illness		Describe
Been diagnosed with a mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Currently being treated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Currently on psychiatric medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Taking medication consistently	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Previous suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
If yes, when?		
Hospitalized for suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
If yes, when?		
Currently suicidal	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Name of psychiatrist/psychologist (if applicable):		

E. Other Issues/Needs

Does client have cultural and/or spiritual beliefs and practices we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any other significant issues we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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). (Client with less than the required days must notify the treatment centre prior to admission).	<input type="checkbox"/> Yes <input type="checkbox"/> No

Personal Strengths:

F. Application Checklist

Confirmation of transportation to Treatment Centre through referral	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confirmation of transportation back home	<input type="checkbox"/> Yes <input type="checkbox"/> No
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.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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 by Saulteaux Healing and Wellness Inc. Clients are required to participate 100% in all programming throughout the 42 days, which includes all group outings. Saulteaux Healing and Wellness Centre Inc. may store my treatment information in the AMIS data base. May disclose a limited summary of my treatment record through AMIS to any other AMIS Participant (Centre) which requests such information in order to treat me and has my consent, The Saulteaux Healing and Wellness Centre Inc. may incorporate the limited summary of my treatment record it receives through AMIS into the treatment centres own files.

Client Signature	Date
Referral Signature	Date

REFERRAL INFORMATION

Name of Referral Agent:	Title:
Name of the Organization:	Email:
Telephone Number:	Fax:

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

Please provide appointment dates: Date 1: Date 2: Date 3: Date 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

SUBSTANCE USE INFORMATION SYSTEM:

What is your drug of choice? 1. _____ 2. _____ 3. _____

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 S = 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 (T2's; T3's) Oxycontin, Dilaudid, Percocet, Darvon, Morphine, Demerol					
Prescription Depressants: Diazepam(Valium), Lorazepam(Ativan), Serax, Rivotril,, Halcion, Librium, Xanax, Barbiturates					
Prescription Stimulants: Ritalin, Dexedrin, Adderall					
Over the Counter Drugs: Codeine(T1's) Gravol, Cough Syrup					

Please provide/attach a brief assessment summary, (Assessment Summaries completed within 6 weeks of this application may be substituted and attached) 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, school, psychological, spiritual, emotional).

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 behaviour within one month
 Action - Begin changing behavior
 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 each item that has been completed:

Check off any items attached to this application:

Item	Attached	Initials
Psychiatric evaluations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Probation order/Court Order	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pending Court Dates	Date: _____	
Current Medical Assessment Form	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assessment Summary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Profile/Assessment (DUSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Item Please initial each item that has been completed:		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		
Does client require special diet? Example: Diabetic		
Allergies to food? Please list		
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)	