**ADULT INTAKE/REFERRAL APPLICATION**

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| **A. General Information** | | | | | | | | | | | | | | | | | | | |
| Date Application Received by Community Worker | | | | | | | | | | | | | | | | Date Application Received by Treatment Centre | | | |
| Surname: | | First Name: | | | | | | | | | | | | | | Nickname or another name known by: | | | |
| Date of Birth: | | Age: | | | | | | | | | | | | | | Sex: | | Provincial Heath Card Number: | |
| Address: | | | | | | | | | | | | | | | | | | Telephone: | |
| Language Spoken: | | Language Preferred: | | | | | | | | | | | | | | Email: | | | |
| Emergency Contact Name: | | | | | | | | | | | | | | | | Telephone: | | Relationship: | |
| Status Indian: | | Status Number: (10-digit status number) | | | | | | | | | | | | | | Band Name: | | | |
|  |  |  |  | |  |  | |  |  | |  | |  |
| Education:  (last grade completed) | | Literacy: ☐ Yes ☐ No ☐ Needs assistance | | | | | | | | | | | | | | Employment Status: | | | |
| **Family/Relationships** | | | | | | | | | | | | | | | | | | | |
| Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Common-Law Yes ☐ Widowed | | | | | | | | | | | | | | | | | | | |
| Does Client have dependent children? | | | | | | | | | | | | | | | | ☐Yes ☐No | | | |
| If yes, do they have access to adequate childcare while in treatment? | | | | | | | | | | | | | | | | ☐Yes ☐No  ☐Not Applicable | |  | |
| Are the children in care? | | | | | | | | | | | | | | | | ☐Yes ☐No  ☐Not Applicable | |  | |
| Child Protection Worker Name:    Child and Family Agency: | | | | | | | | | | | | | | | | Telephone: | | Fax:  Email: | |
| Provide information on client’s children or other dependents: | | | | | | | | | | | | | | | | | | | |
| **Name(s)** | | | | | | | | | | | | | | | | **Age** | | **Relationship** | |
|  | | | | | | | | | | | | | | | |  | |  | |
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| Family Supports: | | | | | | | | | | | | | | | | | | | |
| Family Strengths: | | | | | | | | | | | | | | | | | | | |
| **2023 PROGRAM DATES** ***DETOX REQUIRED***  **INTAKE 048** January 9- February 10, 2023 Deadline: Dec 30/ 2022  **INTAKE 049** February 20 - March 31, 2023 Deadline: Feb 10/ 2023  **INTAKE 050** April 10 – May 19, 2023 Deadline: March 31/ 2023  **INTAKE 051** May 29 – July 7, 2023 Deadline: May 19/2023  **INTAKE 052** July 31- September 8, 2023 Deadline: July 21/2023  *\*CLIENTS MUST BE FULLY VACCINATED AND TESTED PRIOR TO TREATMENT\** | | | | | | | | | | | | | | | | | | | |
| **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** |
|  |  | | | | | | | |  | | | | | | | | ☐Yes ☐No | |  |
|  |  | | | | | | | |  | | | | | | | | ☐Yes ☐No | |  |
|  |  | | | | | | | |  | | | | | | | | ☐Yes ☐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 | | | | | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | | | | | | |  | | | | | |
| Hallucinations | | | | | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | | | | | | |  | | | | | |
| Nausea/Vomiting | | | | | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | | | | | | |  | | | | | |

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| --- | --- | --- | --- |
| Seizures | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | |  |
| Shakes | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | |  |
| Delirium Tremens (DT’s) | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | |  |
| Ever experienced DTs? | ☐Yes ☐No | |  |
| **C. Process/Behavioral Addictions** | | | |
| Has client experienced problems with any of the following? | | | |
| **Process/Behavioral 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 |  |
| **Affiliation:** Are you Affiliated with Street gangs? | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown |  |

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| **Part D: Medical Form**  *To be filled out by a Medical Practitioner & STAMPED*  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?** | | **COVID-19 TEST** |  |  |  |  | | Fully Vaccinated, please provide copy |  |  |  |  | | 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 |  |  |  |  | | Allergies |  |  |  |  |   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 **hot tub 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:** | | Presence of cough lasting more than 2 weeks |  |  |  |  | | Weight loss \_\_\_\_\_\_#lbs. \_\_\_\_\_length of time |  |  |  |  | | Night sweats |  |  |  |  | | Fever |  |  |  |  | | Fatigue |  |  |  |  | | Hemoptysis (blood in sputum) |  |  |  |  | | Recent or past exposure of TB |  |  |  |  | | Previous active TB and treatment |  |  |  |  | | Previous significant Mantoux results or Chest X-ray results |  |  |  |  | | Extensive Travel (or birth) in a country with high incidence of TB |  |  |  |  | | Other risk factors for infection (Living in an area with high incidence of TB, elderly, homeless, health care worker) |  |  |  |  | | Poor general health status and risk factors for progression of disease |  |  |  |  | | **ACTIONS \*\*Please ensure the patient has at least 6 weeks of necessary prescribed medication bubble packed\*\*** | | | | | | Further TB screening or assessment required (if “yes” please fax results to Saulteaux Healing & Wellness Centre, Inc. |  |  |  |  |   **Doctor/Medical Practitioner Signature & STAMP 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 | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | |  | | | | | |
| Currently being treated | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | |  | | | | | |
| Currently on psychiatric medication | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | |  | | | | | |
| Taking medication consistently | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | |  | | | | | |
| Previous suicide attempts | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | | |  | | | | | |
| If yes, when? | |  | | |  | | | | | |
| Hospitalized for suicide attempts | | | ☐Yes ☐No  ☐Not Applicable  ☐Unknown | |  | | | | | |
| If yes, when? | | |  | |  | | | | | |
| Currently suicidal | | | ☐Yes ☐No  ☐Not Applicable  ☐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: | | | | | | | | | | ☐Yes  ☐No |
|  | | | | | | | | | | |
| Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe: | | | | | | | | | | ☐Yes  ☐No |
|  | | | | | | | | | | |
| Are there any other significant issues we need to be aware of? If yes, please describe: | | | | | | | | | | ☐Yes  ☐No |
|  | | | | | | | | | |  |
| Does client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment? | | | | | | | | | | ☐Yes  ☐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). | | | | | | | | | | ☐Yes  ☐No |
|  | | | | | | | | | | |
| Personal Strengths: | | | | | | | | | | |
|  | | | | | | | | | | |
| **F. Application Checklist** | | | | | | | | | | |
| Confirmation of transportation to Treatment Centre through referral | | | | | | | | | | ☐Yes  ☐No |
| Confirmation of transportation back home and is the client aware they need to find own transportation if they don’t complete the program? | | | | | | | | | | ☐Yes  ☐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. | | | | | | | | | | ☐Yes  ☐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 to change, chronic indecision  ☐Determination - Preparation; committed to changing behavior within one month  ☐Action - Begin changing behavior  ☐Maintenance - Behavior 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 | | | | | | | ☐Yes  ☐No | | |  |
| Probation order/Court Order | | | | | | | ☐Yes  ☐No | | |  |
| Pending Court Dates | | | | | | | Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| Current Medical Assessment Form | | | | | | | ☐Yes  ☐No | | |  |
| Assessment Summary | | | | | | | ☐Yes  ☐No | | |  |
| Substance Abuse Profile/Assessment (DUSI) | | | | | | | ☐Yes  ☐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 and you understand you will need to find your own ride home if you don’t complete the WHOLE 6 WEEKS? | | | | | | | | | |  |
| 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) | | | |