SAULTEAUX HEALING & WELLNESS CENTRE INC.

BOX 868 KAMSACK, SK S0A 1S0

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 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**
Family Supports:		
Family Strengths:		

2022	PROGRAM DATES	*DETOX REQUIRED*
INTAKE 042	February 28 – April 8, 2022	Deadline: Feb 14/ 2022
INTAKE 043	April 18 – May 27, 2022	Deadline: Apr 4/ 2022
INTAKE 044	June 6 – July 15, 2022	Deadline: May 23/ 2022
INTAKE 045	August 15 – September 23, 2022	Deadline: Aug 1/ 2022

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	

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/Behavioural Addictions

Has 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	
Affiliation: Are you Affiliated with Street gangs?	☐Yes ☐No ☐Not Applicable ☐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?
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 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:**
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: **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	☐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 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	☐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	
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)