

Treatment Centre - Please check one:

- | | | |
|---|---|--|
| <input type="checkbox"/> Beaver Lake Wah-Pow Treatment Centre | <input type="checkbox"/> Footprints Healing Centre, Alexander | <input type="checkbox"/> Kapown Treatment Centre, Kapawe'no |
| <input type="checkbox"/> Mark Amy Treatment Centre, Fort McMurray | <input type="checkbox"/> Morning Sky Treatment Centre Frog Lake | <input type="checkbox"/> St. Paul Treatment Centre, Standoff |

| | |
|---|--------------------------|
| Office use only - Treatment Centre | |
| Registration date: _____ | Admission date: _____ |
| Actual date of admission: _____ | Cancellation date: _____ |

Part 1 - Client Application

A. General Information

Surname: _____ First Name(s): _____

Nickname or other name known by: _____ Gender: M F Date of birth: MM / DD / YY
 Other:

Languages: spoken _____ preferred _____ understood _____
 Is an interpreter required? Yes No

Status Indian: Yes No First Nation / Band Name: _____

Treaty number (10-digit): _____ Health insurance number: _____

Address (Home): _____ Address (Work): _____

City: _____ Prov: _____ Postal Code: _____ City: _____ Prov: _____ Postal Code: _____

Tel.: _____ Tel.: _____

Marital Status: Single Married / Common law Widowed Divorced / separated

Family type: Living alone With spouse With spouse & children
 Single parent with children Extended family With friends

Number of children and ages: _____

Do your children live with you? Yes, if not all how many? _____ No

Education level (mark only highest level achieved):
 Grade 1-6 Grade 6-9 Grade 9-12 Post-secondary

Legal status: Not applicable Bail Parole Probation Temporary absence
 Other _____

Emergency Contact: _____

Name: _____ Relationship: _____

Address: _____ Tel.: _____

B. Substance Abuse Profile

| | |
|--|-------------|
| Substance... | Last use... |
| A: Last 24 hours B: 2-7 days C: 8-30 days D: over 1 month E: over 1 year | |
| <input type="checkbox"/> A - Alcohol (e.g. beer, whiskey, cough syrup, mouthwash, aftershave, anti-freeze, hairspray) | _____ |
| <input type="checkbox"/> AN - antidepressants, paxil, zoloft, prozac | _____ |
| <input type="checkbox"/> CA - cannabis, marijuana, hashish, hash oil | _____ |
| <input type="checkbox"/> CM - crystal methamphetamine | _____ |
| <input type="checkbox"/> CO - cocaine, crack cocaine | _____ |
| <input type="checkbox"/> H - hallucinogens, angel dust, acid, peyote, magic mushrooms | _____ |
| <input type="checkbox"/> HE - heroin | _____ |
| <input type="checkbox"/> N - narcotics | _____ |
| <input type="checkbox"/> Prescription drugs and over the counter medication | _____ |
| <input type="checkbox"/> Opiates - Tylenol 3, T4, Morphine, Percocet, Oxycontin, etc. | _____ |
| <input type="checkbox"/> Benzodiazepines - Ativan, Valium, Xanax, Serax, Mogadon, Librium | _____ |
| <input type="checkbox"/> Other - Specify | _____ |
| <input type="checkbox"/> S - solvents / inhalants (e.g. gasoline, aerosols, paint thinner, glue, nail polish remover, rush, white out) | _____ |
| <input type="checkbox"/> T - tobacco (e.g. cigarette, cigar, chewing tobacco) | _____ |
| <input type="checkbox"/> O - other | _____ |

Have you participated in a residential treatment program before? Yes No

If yes, please provide information on previous treatment programs:

| Year | Times | Location | Completed? | Dependency |
|-------|-------|----------|--|------------|
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

1. In what way is your drinking or drug taking a problem for you?

2. What are your needs and expectations of the program?

3. List any problems or concerns you may have that could affect your treatment?

4. What are your behaviour patterns when you drink / use (e.g. aggressive, quiet, outgoing, etc.)?

5. I would like to learn about...

C - Other

- Are you allergic to any medication? Yes, please specify _____ No
- Are you allergic to any foods? Yes, please specify _____ No
- Any medical concerns we should be aware of _____
- What are some of the withdrawal symptoms that you experience:

| | | | |
|--|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> blackouts | <input type="checkbox"/> DT's | <input type="checkbox"/> hallucinations | <input type="checkbox"/> hangover |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> seizures | <input type="checkbox"/> shakes | <input type="checkbox"/> dissociation |
| <input type="checkbox"/> other | | | |

D - If requesting admission at Beaver Lake Wah-Pow Treatment Centre

- Number of children to be brought to the program (max. 3 between the ages of 1 year to 4 years) _____
- Is the client breastfeeding? Yes No
- Names and ages of children

- Medical problems for each child

- Any known allergies for each child

- Daycare fee of \$320 per child must be paid prior to client's admission.

E - If requesting admission at Morning Sky Treatment Centre - for the Problem Gambling Program

Is your gambling a source of concern to you or others?

Pattern of gambling (eg: daily, weekends, payday):

Amount of money gambled per occasion?

How long have you gambled?

How long has this been an issue for you?

How has your gambling behaviour affected you and your life (eg: family relationships, employment, health, social life, etc.) ? _____

F. Authorization

I have authorized the documentation of this information. I understand and agree to accept the treatment program as prescribed by the Treatment Centre.

Signature

Date

Part 2 - Referral Information

Name: _____ Title: _____ Referral Agency: _____

Address: _____ Tel.: _____

E-mail: _____ Fax: _____

- What are the clients' current issues? What is his / her insight of the issue?
- Does the applicant require detoxification? Yes No
- Will you continue to see the client once he/she has completed treatment? Yes No
- Is there an aftercare plan in place? Yes No
- Has the client signed and agreed to an aftercare plan (*Forward aftercare plan to centre*) Yes No

Please forward the applicant's results on the assessments used.

Why do you think this client wants treatment?

Give an evaluation of how the applicant's use of alcohol and/or drugs and/or gambling/gaming created problems in the following areas:

- Domestic _____
- Medical _____
- Social _____
- Psychological _____
- Financial _____
- Emotional _____

Development of problem

- Age when regular use began _____
- Age when problems first began to occur _____
- Gradual increase over a long time _____ Sudden rapid increase _____
- Any special circumstances surrounding the beginning of problem _____

Describe in detail the most important areas for the applicant to address in treatment?

- Abandonment _____
- Anger _____
- Grieving _____
- Parenting skills _____
- Sexual abuse _____
- Rejection _____
- Financial _____

Is the client affiliated with a criminal gang Yes No If yes, and if affiliation is known, please specify: _____

Signature

Date



Part 3 - Medical Assessment: All applicants 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 honoured.

Applicant's Name: _____ Treaty Number (10 digit): _____

A. Any history of... Please explain any "yes" responses in section B

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Central Nervous System Disorder (i.e. memory loss, poor concentration, peripheral neuropathy) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Chronic bronchitis, asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Heart problems - Current blood pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Gastrointestinal problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Liver problems: Hepatitis B & C |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Pancreatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Kidney or urinary problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Sexually Transmitted Diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Diabetes / hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Chronic pain |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Allergies: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Eating disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Sleep disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Withdrawal symptoms, seizures, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Any other medical problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Medical confirmation of pregnancy _____ weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Mood disorders (e.g., major depressive disorder, bipolar disorder...) |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Psychotic disorders (e.g., schizophrenia) |

When was the patients most recent sputum sample for acid-fast bacilli, and what was the result?

C. TB Screening: Symptoms & History

- | Date of Onset if Yes | Yes | No | |
|----------------------|--------------------------|--------------------------|--|
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 1. Presence of cough lasting more than two weeks. |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 2. Weight Loss: # of pounds: _____ Length of time: _____ |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 3. Night sweats |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 4. Fever |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 5. Fatigue |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 6. Haemoptysis (blood sputum) |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 7. Recent or past exposure to TB |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 8. Previous active TB and treatment |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 9. Previous significant Mantoux results or chest x-ray results |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 10. Correctional facility residence |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 11. Poor General health status and risk factors for progression of disease |

N.B. Confirmation from the physician and/or public health nurse that the applicant is free from active TB must be received prior to confirmation of residential treatment admission date.

D. Are there any special problems (physical or psychological) that should be considered in the treatment of this applicant (i.e. difficulty with stairs or long corridors, anxiety attacks, etc.)?

E. Current medications(including prescription medications and over-the-counter drugs)

| Drug Name | Dose/Schedule | Prescribed by | Length of time used | Clinical Indication |
|-----------|---------------|---------------|---------------------|---------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

REMINDER TO THE PHYSICIAN: for the patient’s safety and wellness while in residential treatment, please arrange with the patient’s pharmacy for compliance packaging of medications for the duration of treatment.

Past and present mental health problems (i.e. depression, psychosis including hospitalization):

Describe any:

Please remind the applicant: In order to be admitted to residential treatment, the applicant must remain alcohol and drug free for at least 5 days prior to their admission date, 14 days for patients using BZD, and be well enough to participate in the program.

Are you the applicant’s regular physician? Yes No

Physician’s signature: _____ Date: _____

Physician’s name: _____ Tel.: _____ Fax: _____

Address: _____ City: _____ Postal Code: _____

I hereby authorize the above named physician to release the information to the National native Alcohol and Drug Abuse Program and its staff as required to assess my suitability for acceptance and admittance to the residential treatment program.

Applicant’s signature: _____ Date: _____



Part 4 - Applicant Checklist

- Letter of confirmation; indicating medical, dental, optical, financial and legal matters have been dealt with
- Confirmation of transportation to Treatment Centre
- Confirmation of transportation back home (covered by Non-Insured Health Benefits if the treatment is completed)
- Notified that transportation back home will be provided by Non-Insured Health Benefits only if the program is completed
- Suggested items needed:
 - toiletries (toothbrush, toothpaste, shampoo, deodorant, etc.)
 - bathing suits and shorts
 - warm clothing
 - 2 pair of running shoes for indoor / outdoor activities
 - towel and facecloths
 - medications (Non-Prescription and Physician prescribed **MUST BE** handed in to intake worker upon arrival)
(Both prescription and non-prescription drugs)
 - provincial health care card (or photocopy of health care card)
 - valid identification card
 - money

Beaver Lake Wah-Pow Treatment Centre - admission with children

- Photocopy of Child Immunization record
- Provincial health card(s) or photocopy of health card
- Children's medical records
- Supplies for children's care (e.g. diapers, wipes, inside shoes, etc.)
- Daycare fee of \$320 per child

If I self-terminate or I am terminated from the treatment program, Non-Insured Health Benefits will pay for return trip, however I will be responsible for transportation for my next medical appointment.

- I have completed the required 4 pre-treatment counselling sessions.**

Signature

Date

Part 5 - Referral Checklist

| | Initials |
|---|----------|
| FNIHB pre-authorization treatment services has been received (4 in total) | _____ |
| All medical, dental and optical appointments have been dealt prior to admission | _____ |
| All financial matters have been dealt prior to treatment | _____ |
| All legal matters have been dealt prior to treatment | _____ |
| Full up-to-date medical assessment form have been completed and forwarded to the treatment centre | _____ |
| If client paid for the medical assessment out-of-pocket, the client has been provided the information for reimbursement through Non-Insured Health Benefits | _____ |
| Confirmation of transportation to the Treatment Centre | _____ |
| Confirmation of transportation back to home after completion of the program | _____ |
| Client has been notified that transportation back home will be provided by Non-Insured Health Benefits only if the program is completed | _____ |
| Relapse prevention plan has been submitted to the Treatment Centre | _____ |
| Proper documentation (e.g. intake forms, medical assessments, assessments (i.e. SASSI) has been submitted to the Treatment Centre | _____ |
| Beaver Lake Wah-Pow Detox Treatment Centre - admission with children | _____ |
| • Have health nurse check for head lice on all children | _____ |

 Signature

 Date