



Pelican High Peak
Youth Healing Lodge
70 Wellington Street
Sioux Lookout, ON P8T 1E1



Ka-Na-Chi-Hih Specialized
Solvent Abuse Treatment Centre
1700 Dease Street
Thunder Bay, ON P7C 5H4



Wakenagun
Youth Healing Lodge
5310 Highway 101 West
Timmins, ON P4R 0B5

CENTRALIZED REFERRAL FORM

***PLEASE NOTE: ALL SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL.**
Incomplete forms will be returned and may delay the intake process.

PLEASE CHECK OFF WHICH HEALING LODGE YOU ARE APPLYING FOR:

KA-NA-CHI-HIH (18-29 YEARS OLD)

WAKENAGUN (12-17 YEARS OLD)

PELICAN HIGH PEAK (12-17 YEARS OLD)

PART 1 – APPLICATION

A. PERSONAL INFORMATION

FIRST NAME: _____ LAST NAME: _____ MIDDLE NAME: _____

AGE: _____ DATE OF BIRTH (mm/dd/yyyy): _____ GENDER: _____ SEX: _____

ADDRESS: _____ PROVINCE/TERRITORY: _____ POSTAL CODE: _____

MARITAL STATUS: _____ PHONE #: _____

EMAIL: _____

HEALTH CARD #: _____ VERSION CODE: _____ EXPIRY DATE: _____

BAND NAME: _____ STATUS CARD #: _____

STATUS INDIAN

INUIT

MÉTIS

NON-STATUS

LANGUAGE(S) SPOKEN: _____ LANGUAGE(S) UNDERSTOOD: _____

REASON FOR REFERRAL:

B. PRIMARY CAREGIVER / EMERGENCY CONTACT INFORMATION

PRIMARY CAREGIVER

FIRST NAME: _____ LAST NAME: _____ MIDDLE NAME: _____

RELATIONSHIP TO YOU: _____ ADDRESS: _____

PROVINCE/TERRITORY: _____ POSTAL CODE: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

FAX: _____ EMAIL: _____

EMERGENCY CONTACT (IF DIFFERENT FROM PERSONS ABOVE)

FIRST NAME: _____ LAST NAME: _____ MIDDLE NAME: _____
RELATIONSHIP TO YOU: _____ ADDRESS: _____
PROVINCE/TERRITORY: _____ POSTAL CODE: _____ HOME PHONE: _____
CELL PHONE: _____ WORK PHONE: _____
FAX: _____ EMAIL: _____

C. REFERRAL INFORMATION

REFERRAL SOURCE: _____
FULL NAME: _____ RELATIONSHIP TO YOU: _____
WORK PHONE: _____ CELL PHONE: _____
FAX: _____ EMAIL: _____

IF WE CANNOT REACH YOU, IS THERE SOMEWHERE WE HAVE CONSENT TO LEAVE A MESSAGE FOR YOU?

D. LEGAL INFORMATION

DO YOU HAVE ANY CURRENT ISSUES WITH THE LAW? YES NO

IF YES, PLEASE LIST ALL LEGAL CHARGE(S) / OFFENCE(S), INCLUDING ANY THAT ARE PENDING: _____

PLEASE CHECK OFF ALL THAT APPLY:

CRIMINAL COURT	FAMILY COURT	DRUG COURT TREATMENT	PROBATION
CHARGES PENDING	COURT REFERRAL	COURT ORDER	RESTORATIVE JUSTICE
NO INVOLVEMENT			

DO YOU CURRENTLY HAVE A PROBATION OFFICER? YES NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF PROBATION OFFICER: _____

PHONE #: _____ FAX #: _____

EMAIL: _____

PROBATION ORDER – FROM: _____ TO: _____

CONDITIONS: _____

DO YOU CURRENTLY HAVE A LAWYER?

YES

NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF LAWYER: _____

PHONE #: _____

FAX #: _____

EMAIL: _____

ARE YOU REQUIRED TO ATTEND COURT, IF YES, PLEASE PROVIDE DATE, TIME, AND A COPY OF THE ORDER:

WERE ANY MIND-ALTERING SUBSTANCES INVOLVED DURING YOUR LEGAL PROBLEMS?

YES

NO

IF YES, PLEASE EXPLAIN: _____

HAVE YOU EVER BEEN INVOLVED OR HAD ANY CURRENT GANG INVOLVEMENT?

YES

NO

UNKNOWN

- **ALL INFORMATION PERTAINING TO CURRENT LEGAL MATTERS AND PROBATION ORDERS ARE REQUIRED TO BE FORWARDED WITH THE REFERRAL PACKAGE.**
- **NO REFERRAL WILL BE CONSIDERED UNTIL ALL DOCUMENTS ARE OBTAINED.**
- **CRITICAL INFORMATION THAT IS WITHHELD, FALSE, MISLEADING, OR FABRICATED MAY RESULT IN DISCHARGE, ESPECIALLY IN THE EVENT WHERE THE SAFETY OF OTHERS IS AT RISK.**

E. FAMILY HISTORY

DO YOU HAVE ANY DEPENDENT CHILDREN?

YES

NO

IF YES, WILL THEY HAVE ACCESS TO ADEQUATE CHILDCARE WHILE YOU ARE IN TREATMENT?

YES

NO

ARE THE CHILDREN IN CARE?

YES

NO

DO YOU HAVE OTHER DEPENDENTS?

YES

NO

WHAT IS YOUR CURRENT LIVING SITUATION? (CHECK OFF ALL THAT APPLY):

ON-RESERVE

IMMEDIATE FAMILY

GROUP HOME

OFF-RESERVE

EXTENDED FAMILY

SHELTER

URBAN

LIVES ALONE

FOSTER CARE

RURAL

HOMELESS

COMMON LAW

FRIEND

HAS THERE OR IS THERE CURRENTLY ANY CHILD WELFARE INVOLVEMENT?

YES

NO

UNKNOWN

HAS ANYONE IN YOUR FAMILY OR COMMUNITY RECEIVED TREATMENT FOR SUBSTANCE USE?

YES

NO

IF YES, PLEASE EXPLAIN: _____

F. EDUCATION

ARE YOU CURRENTLY ATTENDING SCHOOL? YES NO

HIGHEST GRADE COMPLETED: _____

NAME OF LAST SCHOOL ATTENDED: _____

LAST YEAR ATTENDING THIS SCHOOL: _____

SCHOOL PHONE NUMBER AND/OR CONTACT INFORMATION: _____

DO YOU HAVE ANY SPECIAL NEEDS, LEARNING DISABILITIES, OR BEHAVIOURAL PROBLEMS THAT WE NEED TO BE AWARE OF? YES NO

IF YES, PLEASE EXPLAIN: _____

G. MEDICAL HISTORY

DO YOU HAVE ANY MEDICAL CONDITIONS? YES NO

IF YES, PLEASE IDENTIFY: _____

FAMILY DOCTOR'S NAME & PHONE NUMBER (if applicable): _____

PLEASE PROVIDE THE DATES OF YOUR LAST APPOINTMENTS FOR EACH OF THE FOLLOWING (approximately):

MEDICAL: _____

DENTAL: _____

OPTICAL: _____

DO YOU HAVE ANY ALLERGIES? YES NO

IF YES, PLEASE LIST ANY ALLERGIES AND THE REACTION TO THE ALLERGY:

PLEASE LIST ANY MEDICAL NEEDS WHILE ATTENDING PROGRAM:

ARE YOU CURRENTLY ON ANY MEDICATION? YES NO

****Please ensure the Medical Assessment (PART 2) is completed by a Health Professional and attached to this application form.***

H. SUBSTANCE USE HISTORY

AT WHAT AGE DID YOU START DRINKING ALCOHOL? _____ NOT APPLICABLE

AT WHAT AGE DID YOU START TAKING OTHER DRUGS? _____ NOT APPLICABLE

AT WHAT AGE DID YOU START USING SOLVENTS? _____ NOT APPLICABLE

HAVE YOU EVER GOTTEN INTO ANY PHYSICAL FIGHTS WHILE USING? YES NO

HAVE YOU EVER CAUSED SERIOUS INJURY TO SELF OR OTHERS WHILE USING? YES NO

IF YES, PLEASE EXPLAIN: _____

DO YOU REQUIRE A WITHDRAWAL MANAGEMENT PLAN BEFORE YOU ATTEND THE PROGRAM?

HAVE YOU BEEN IN PREVIOUS TREATMENT FOR YOUR USE OF SUBSTANCES? YES NO

IF YES, PLEASE INDICATE WHERE, WHEN, HOW LONG YOU STAYED IN THE PROGRAM, AND THE REASON FOR DISCHARGE: _____

HAVE YOU PARTICIPATED IN A NON-RESIDENTIAL / COMMUNITY BASED SUBSTANCE USE AND/OR MENTAL HEALTH PROGRAM? YES NO

IF YES, PLEASE LIST THE TYPES OF PROGRAM(S): _____

I. PSYCHOLOGICAL FUNCTIONING

HAVE YOU EVER SPOKEN OR WRITTEN ABOUT KILLING YOURSELF? YES NO

HAVE YOU EVER ATTEMPTED TO KILL YOURSELF? YES NO

IF YES, HOW MANY TIMES AND HOW LONG AGO? _____

HOW DID YOU ATTEMPT TO KILL YOURSELF? _____

HAVE YOU EVER TAKEN PART IN SELF-HARMING BEHAVIOURS? IF YES, PLEASE EXPLAIN:

DO YOU HAVE DIFFICULTLY WITH ANGER? IF YES, PLEASE EXPLAIN: _____

DO YOU REQUIRE BEHAVIOURAL MANAGEMENT? IF YES, PLEASE EXPLAIN: _____

HAVE YOU EVER DEMONSTRATED CRUELTY TO ANIMALS? IF YES, PLEASE EXPLAIN: _____

DO YOU HAVE A HISTORY OF AGGRESSION TOWARDS OTHERS? IF YES, PLEASE EXPLAIN: _____

DO YOU HAVE A HISTORY OF FIRE SETTING? IF YES, PLEASE EXPLAIN: _____

DO YOU HAVE A HISTORY OF DESTROYING PROPERTY? IF YES, PLEASE EXPLAIN: _____

IS THERE ANY KNOWN HISTORY OF SEXUAL ABUSE?	YES	NO	UNKNOWN
IS THERE ANY KNOWN HISTORY OF PHYSICAL ABUSE?	YES	NO	UNKNOWN
IS THERE ANY KNOWN HISTORY OF EMOTIONAL ABUSE?	YES	NO	UNKNOWN

IS THERE ANY HISTORY OF FAMILY VIOLENCE THAT YOU MAY HAVE BEEN WITNESS TO?

YES	NO	UNKNOWN
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HAVE YOU EVER HAD ANY PSYCHOLOGICAL TESTING OR COUNSELLING?	YES	NO
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IF YES, FOR WHAT PURPOSE? _____

****Please attach any psychological / mental health assessment(s) conducted to-date (i.e., psycho-educational, SASSI, MAST, DAST, etc.).***

PLEASE INDICATE WHETHER YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS OR SPECIFY IF ANY OTHER DIAGNOSES:

DISORDER	DIAGNOSED
FETAL ALCOHOL SPECTRUM DISORDER (FASD)	
OPPOSITIONAL DEFIANT DISORDER (ODD)	
CONDUCT DISORDER (CD)	
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)	
ATTENTION DEFICIT DISORDER (ADD)	
OTHER:	

WHEN IN A SOBER STATE...

HAVE YOU COMMUNICATED WITH SPIRITS NO ONE ELSE CAN SEE OR HEAR?

NONE OF THE TIME

SOME OF THE TIME

MOST OF THE TIME

ALL OF THE TIME

ARE THESE ENCOUNTERS POSITIVE OR NEGATIVE EXPERIENCES FOR YOU?

POSITIVE

NEGATIVE

INDIFFERENT

ARE THERE TIMES WHEN PEOPLE ARE UNABLE TO COMMUNICATE WITH YOU?

NONE OF THE TIME

SOME OF THE TIME

MOST OF THE TIME

ALL OF THE TIME

PLEASE EXPLAIN: _____

J. OUTSIDE RESOURCES

ARE THERE ANY OTHER AGENCIES IN YOUR CIRCLE OF CARE?

YES

NO

IF YES, WHICH AGENCIES AND WHAT SERVICES DO THEY PROVIDE? (i.e., NNADAP, CHR, CFS):

NAME OF AGENCY / RESOURCE PERSON	DESCRIPTION OF SUPPORT	CONTACT INFORMATION

K. CLOTHING INFORMATION

THIS INFORMATION IS FOR STAFF TO ENSURE YOU HAVE THE PROPER APPAREL FOR LAND-BASED ACTIVITIES AND TO ASSIST WITH REPLACEMENT IF SOMETHING HAS BEEN DAMAGED DURING YOUR STAY.

PLEASE PROVIDE US WITH YOUR CLOTHING SIZES BELOW:

SHIRT SIZE: _____

PANT SIZE: _____

SHOE SIZE: _____

BRA SIZE (if applicable): _____

UNDERWEAR SIZE: _____

**Please submit your completed referral form to the Continuous Care Facilitator,
Samantha Birnie at the following:*

- Email: sbirnie@kanachihih.ca
- OR
- Fax: +18077899803

*OR simply press this green 'Submit
Form' button to submit your completed
referral form pre-attached to an email.*



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PART 2 – MEDICAL ASSESSMENT

**To be completed by a Health Professional (i.e., Physician, Nurse Practitioner, Nurse) prior to admittance into the treatment program.*

Please complete this section in a CLEAR manner.

PATIENT'S NAME: _____

D.O.B (mm/dd/yyyy): _____ BAND NAME: _____

HEALTH CARD #: _____ STATUS CARD #: _____

DATE OF EXAM: _____

A. MEDICAL HISTORY (Please explain any 'YES' responses in Section B)

CONDITION	DIAGNOSED / HISTORY OF:	
	YES and DATE	NO
Anemia		
Back Injury / Problems		
Brain Injury		
Cardiovascular Problems		
Cognition Problems		
Chicken Pox		
Dental Pain (tender jaw, toothache, temperature sensitivities, other – please specify): >		
Disease / Injury of Bones of Joints		
Diabetes / Hypoglycemia (please specify): >		
Ear, Nose, Throat Problems		
Eating Disorders		
Eye Problems		
Epilepsy		
Fainting		

CONDITION	DIAGNOSED / HISTORY OF:	
	YES and DATE	NO
Feet Problems (orthotics, foot pain, toenail pain, other – please specify): >		
Hallucinations / Delusions		
Heart Problems		
Hepatitis (A, B or C, please indicate): >		
Respiratory Problems		
Gastrointestinal Problems		
Pancreatic Problems		
Kidney or Urinary Problems		
Learning Disability		
Tuberculosis		
Chronic Pain		
Sleep Disorder		
Withdrawal Symptoms (seizures, other – please indicate): >		
Mental Health (please indicate): >		
HIV / AIDS		
Sexually Transmitted Disease (please indicate): >		
Medical Confirmation of Pregnancy (if applicable, please indicate # of weeks): >		
Allergies (drug, food, other – please indicate): >		
Tobacco Use		
Skin Conditions		
Self-Harm (cutting, burning, other)		
Suicidal Ideation / Suicide Attempt(s)		
Surgery (please indicate): >		

Other: > >		
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B. PHYSICAL EXAMINATION

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ PULSE: _____

Please indicate if the following areas listed below are observed to have 'No Concerns' during the physical examination:

AREA	NO CONCERNS	AREA	NO CONCERNS
Cardiovascular		Musculoskeletal System	
Cognition		Neuropsychiatry	
Ears, Nose, Throat (system review)		Lymph Nodes	
Eyes		Respiratory	
Hygiene (standard)		Skin	
Mental Health		Other:	

If 'YES' was indicated for any areas in Section A or any areas during Section B were observed to have concerns, please explain:

C. CURRENT PRESCRIPTION MEDICATIONS

Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. Please note: Mood altering medications must be prescribed and monitored by a psychiatrist for management of a mental illness. If more space is required, please attach a current medication list with the application.

MEDICATION	DOSE	FREQUENCY	START DATE	END DATE	INDICATION (USED FOR?)

Reminder to Health Professional: For the client's safety and well-being while at the Healing Lodge, please ensure that all prescription medication(s) are transferred to the appropriate pharmacy of choice listed below **one week prior** to the admission date.

HEALING LODGE	PHARMACY OF CHOICE	PHARMACY CONTACT INFORMATION
Ka-Na-Chi-Hih	Janzen's Pharmacy – The Link 300 Lillie St. N., Thunder Bay, ON.	Phone: (807) 344-0405 Fax: (807) 344-0483
Wakenagun	Shoppers Drug Mart 227 Algonquin Blvd. W., Timmins, ON.	Phone: (705) 264-4311 Fax: (705) 264-0199
Pelican High Peak	Sioux Lookout Remedy's Rx 75 King St., Sioux Lookout, ON.	Phone: (807) 737-4998 Fax: (807) 737-7174

IN YOUR OPINION, IS THIS CLIENT MEDICALLY STABLE AND APPROPRIATE FOR ADMISSION TO A RESIDENTIAL ADDICTION TREATMENT PROGRAM? YES NO

In the past 6 months, has the client been using the medication appropriately? YES NO N/A

If NO, please explain: _____

IS THE CLIENT VACCINATED FOR COVID-19?

NO

YES (1st shot only)

YES (2 shots only)

YES (2 shots plus booster(s))

IS THE PROOF OF VACCINATION ATTACHED TO THE ADMISSION FORM?

YES

NO

D. OVER-THE-COUNTER MEDICATIONS & TRADITIONAL MEDICINES

Please indicate if there are any concerns or side effects that we need to be made aware of with this client regarding the use of over-the-counter medications and traditional medicines if taken with current prescription medication(s):

OVER-THE-COUNTER MEDICATIONS	CONCERNS OR SIDE EFFECTS
Tylenol	
Advil	
Cold Medication	
Melatonin	
Other: >	
TRADITIONAL MEDICINES	CONCERNS OR SIDE EFFECTS
Cedar Tea	
Labrador Tea	
Bear Grease (topical)	
Other: >	

E. HEALTH PROFESSIONAL'S INFORMATION

HEALTH PROFESSIONAL'S FULL NAME (print): _____

JOB TITLE: _____ DATE: _____

ADDRESS: _____

PROVINCE/TERRITORY: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

EMAIL: _____

HEALTH PROFESSIONAL'S SIGNATURE: _____

OTHER (i.e., psychiatrist or specialist relevant to this admission): _____

PHONE: _____

FAX: _____

EMAIL: _____

F. CLIENT CONSENT TO RELEASE INFORMATION

I hereby authorize the above-named health professional to release the information to the appropriate Healing Lodge and relevant staff, as required, to assess my suitability for acceptance and admittance into the treatment program.

PARENT/LEGAL GUARDIAN/CLIENT SIGNATURE

DATE