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 ADMISSION 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 AGE GROUP THE APPLICANT FALLS UNDER:

RESET/CLEAR FORM

- ◯ **ADULT (18-29 YEARS OLD)**
- ◯ **YOUTH (12-17 YEARS OLD)**

PART 1 – APPLICATION

A. PERSONAL INFORMATION

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

AGE: _____ DATE OF BIRTH: _____ GENDER: _____ STATUS CARD #: _____

ADDRESS: _____ RESERVE/MUNICIPALITY: _____

PROVINCE: _____ POSTAL CODE: _____ HOME PHONE: _____

CELL PHONE: _____ EMAIL: _____

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

BAND NAME: _____

◯ STATUS INDIAN ◯ INUIT ◯ MÉTIS

LANGUAGE SPOKEN: _____ LANGUAGE UNDERSTOOD: _____

REASON FOR ADMISSION:

B. PRIMARY CAREGIVER / EMERGENCY CONTACT INFORMATION

PRIMARY CAREGIVER

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

RELATIONSHIP: _____ ADDRESS: _____

RESERVE / MUNICIPALITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE: _____

FAX: _____ CELL PHONE: _____

EMAIL: _____

EMERGENCY CONTACT (DIFFERENT FROM PERSONS ABOVE)

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

RELATIONSHIP: _____ ADDRESS: _____

RESERVE / MUNICIPALITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE: _____

FAX: _____ CELL PHONE: _____

EMAIL: _____

C. REFERRAL INFORMATION

REFERRAL SOURCE: _____

FULL NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

FAX: _____ CELL PHONE: _____

EMAIL: _____

D. LEGAL INFORMATION

LEGAL STATUS

PLEASE CHECK THE BOX THAT APPLIES:

- ☐ TEMPORARY CARE AGREEMENT
- ☐ CUSTOMARY CARE AGREEMENT
- ☐ SOCIETY WARDSHIP
- ☐ CROWN WARDSHIP
- ☐ KINSHIP AGREEMENT
- ☐ INTERIM CARE AGREEMENT
- ☐ SUPERVISION ORDER
- ☐ UNKNOWN
- ☐ NO INVOLVEMENT
- ☐ CRIMINAL COURT
- ☐ FAMILY COURT
- ☐ DRUG COURT TREATMENT
- ☐ PROBATION
- ☐ CHARGES PENDING
- ☐ COURT REFERRAL
- ☐ COURT ORDER
- ☐ RESTORATIVE JUSTICE

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

IF YES, PLEASE EXPLAIN: _____

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: _____

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

_____

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

_____

_____

WAS ALCOHOL OR ANY OTHER SUBSTANCES, SUCH AS "SNIFF" OR DRUGS INVOLVED DURING YOUR CLIENT'S LEGAL PROBLEMS? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

_____

HAS CLIENT BEEN INVOLVED OR HAS 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 ADMISSION WILL BE CONSIDERED UNTIL ALL DOCUMENTS ARE OBTAINED.**
- **CRITICAL INFORMATION THAT IS WITHHELD, FALSE, MISLEADING, OR FABRICATED MAY RESULT IN THE CLIENTS DISCHARGE, ESPECIALLY IN THE EVENT WHERE THE SAFETY OF OTHERS IS AT RISK.**

E. FAMILY HISTORY

BIOLOGICAL MOTHER'S NAME: _____

IF DECEASED, HER AGE AT DEATH: _____ AGE OF CLIENT AT TIME OF HER DEATH: _____

BIOLOGICAL FATHER'S NAME: _____

IF DECEASED, HIS AGE AT DEATH: _____ AGE OF CLIENT AT TIME OF HIS DEATH: _____

DOES CLIENT HAVE DEPENDENT CHILDREN? ◯ YES ◯ NO

IF YES, DO THEY HAVE ACCESS TO ADEQUATE CHILDCARE WHILE IN TREATMENT? ◯ YES ◯ NO

ARE THE CHILDREN IN CARE? ◯ YES ◯ NO

DOES THE CLIENT HAVE OTHER DEPENDENTS? ◯ YES ◯ NO

PLEASE COMPLETE THE FOLLOWING TABLE ON CLIENT'S CHILDREN OR OTHER DEPENDENTS (IF APPLICABLE):

NAME	AGE	RELATIONSHIP

WHO DOES CLIENT LIVE WITH?

◯ MOM ONLY ◯ DAD ONLY ◯ MOM & DAD ◯ ALONE ◯ FRIENDS

◯ SIBLINGS ◯ EXTENDED FAMILY MEMBERS ◯ FOSTER CARE

◯ OTHER, PLEASE SPECIFY: _____

HAS THERE OR IS THERE CURRENTLY ANY CHILD WELFARE INVOLVEMENT? ◯ YES ◯ NO ◯ UNKNOWN

IF YES, WHAT IS THE CLIENT'S CURRENT STATUS, PLEASE CHECK THE BOX THAT APPLIES:

◯ CROWN WARD ◯ VOLUNTARY PLACEMENT ◯ VOLUNTARY PLACEMENT AGREEMENT (VPA)

◯ SOCIETY WARD ◯ CUSTOMARY CARE ◯ OTHER, PLEASE SPECIFY: _____

DOES CLIENT HAVE ANY SIBLINGS? ◯ YES ◯ NO

IF YES, PLEASE COMPLETE THE FOLLOWING TABLE ON CLIENT'S SIBLING(S):

NAME	AGE	GENDER	HEALTH STATUS	LIVES WITH

PLEASE INDICATE OTHER PERSONS YOU LIVE WITH, NOT INCLUDING SIBLINGS:

OTHER PERSONS LIVING IN THE HOME			
NAME	**AGE**	**GENDER**	**RELATIONSHIP**

CLIENTS BELIEF SYSTEM: ◯ TRADITIONAL ◯ CATHOLIC ◯ PROTESTANT ◯ ANGLICAN
◯ NONE ◯ OTHER: _____

F. EDUCATION

IS THE CLIENT CURRENTLY REGISTERED IN SCHOOL? ◯ YES ◯ NO

IS THE CLIENT CURRENTLY ATTENDING SCHOOL? ◯ YES ◯ NO

IF YOU ANSWERED 'NO' TO 1 OF THE 2 ABOVE QUESTIONS, PLEASE EXPLAIN: _____

_____

DOES THE CLIENT LIKE SCHOOL? ◯ YES ◯ NO

HIGHEST GRADE COMPLETED? _____

LAST SCHOOL ATTENDED: _____

LAST YEAR ATTENDING THIS SCHOOL: _____

DID CLIENT EVER ATTEND SCHOOL WHILE HIGH ON DRUGS, ALCOHOL, AND/OR SOLVENTS? ◯ YES ◯ NO

IS TRUANCY (ABSENTEEISM) A PROBLEM FOR CLIENT? ◯ YES ◯ NO

DOES THE CLIENT HAVE ANY SPECIAL NEEDS, LEARNING DISABILITIES, OR BEHAVIOURAL PROBLEMS THAT WE NEED TO BE AWARE OF? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

DID THE EDUCATIONAL INSTITUTE THAT CLIENT ATTENDED EVER PREPARE AN INDIVIDUAL EDUCATION PLAN (IEP) FOR CLIENT? ◯ YES ◯ NO ***If yes, please attach a copy of the IEP to this application*.**

G. RELATIONSHIPS

WHAT KIND OF RELATIONSHIPS DOES THE CLIENT HAVE WITH ANY OF THE FOLLOWING:

PARENT(S): _____

SIBLING(S), if any: _____

EXTENDED FAMILY MEMBER(S): _____

IS THE CLIENT SATISFIED WITH THEIR FAMILY RELATIONSHIPS? ◯ YES ◯ NO

IF NO, PLEASE EXPLAIN: _____

NAME OF PERSON THE CLIENT FEELS CLOSEST TO AND WHY? PROVIDE DETAILS: _____

_____

FAMILY SUPPORTS: _____

FAMILY STRENGTHS: _____

DOES CLIENT MAKE FRIENDS EASILY? ◯ YES ◯ NO

DOES CLIENT HAVE ANY CLOSE FRIENDS? ◯ YES ◯ NO

IF YES, WHO? _____

HAS THE CLIENT EVER BEEN INVOLVED WITH ANY OF THE FOLLOWING GROUPS? SELECT ALL THAT APPLY:

☐ CHURCH ☐ SOCIAL CLUB(S) ☐ SPORTS ☐ TRADITIONAL PRACTICES

☐ OTHER, PLEASE SPECIFY: _____

DOES THE CLIENT FEEL THAT THEY FIT IN WELL WITH ANY OF THE ABOVE GROUPS? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

DOES CLIENT CURRENTLY HAVE A GIRLFRIEND / BOYFRIEND? ◯ YES ◯ NO

IS CLIENT SEXUALLY ACTIVE? ◯ YES ◯ NO

DOES CLIENT TALK TO ANY ELDERS? ◯ YES ◯ NO

IS CLIENT WILLING TO LISTEN TO ELDERS? ◯ YES ◯ NO

H. MEDICAL HISTORY

DOES THE CLIENT HAVE ANY MEDICAL CONDITIONS? ◯ YES ◯ NO

IF YES, PLEASE IDENTIFY: _____

DOES THE CLIENT REQUIRE A MEDICAL CONSENT FORM? ◯ YES ◯ NO

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

PLEASE PROVIDE THE DATES OF THE CLIENT'S LAST APPOINTMENTS FOR EACH OF THE FOLLOWING:

MEDICAL: _____

DENTAL: _____

OPTICAL: _____

DOES CLIENT HAVE ANY ALLERGIES? ◯ YES ◯ NO

IF YES, PLEASE LIST ANY ALLERGIES FOR CLIENT: _____

_____

PLEASE LIST ANY SPECIAL NEEDS OF THE CLIENT: _____

_____

IS CLIENT CURRENTLY ON ANY MEDICATION? ◯ YES ◯ NO

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

I. CHEMICAL USE HISTORY

AT WHAT AGE DID THE CLIENT START SNIFFING SOLVENTS? _____ ☐ NOT APPLICABLE

AT WHAT AGE DID THE CLIENT START DRINKING ALCOHOL? _____ ☐ NOT APPLICABLE

AT WHAT AGE DID THE CLIENT START TAKING OTHER DRUGS? _____ ☐ NOT APPLICABLE

PLEASE INDICATE IF CLIENT HAS EVER USED ANY OF THE FOLLOWING SUBSTANCES:

SUBSTANCE *(indicate all that apply)*	**YES**	**NO**	**LAST USE** *(i.e., # of hours, days, weeks, months, years)*	**APPROXIMATE AMOUNT PER USE**
Solvents / Inhalants – gasoline, glues, paint thinner, aerosol sprays, nail polish remover or other: _____	◯	◯		
Alcohol – beer, liquor, cough syrup, mouthwash, aftershave, hand sanitizer, or other: _____	◯	◯		
Cannabis – Marijuana, hash, hash oil	◯	◯		
Hallucinogens – Ecstasy, Magic, LSD, Mushrooms, peyote, or other: _____	◯	◯		
Stimulants – Crystal Meth, Crystal, JIB, Sister, GIB, Ice, Speed, or other: _____	◯	◯		

Cocaine – Crack, Crack Cocaine, Angie, Blow, Coke, Rock, Snow, Stardust, or other: _____	◯	◯		
Depressants – Xanax, Ativan, Librium, Serax, Heroin, Methadone, or other: _____	◯	◯		
Stimulants – Dexedrine, Adderall, Ritalin, or other: _____	◯	◯		
Tobacco – Cigarettes or Chewing Tobacco	◯	◯		
Other:	◯	◯		

DOES ANYONE ELSE IN THE CLIENT'S FAMILY USE SUBSTANCES? ◯ YES ◯ NO

IF YES, PLEASE PROVIDE NAME(S) OF FAMILY MEMBER(S) & SUBSTANCE(S) USED: _____

_____

WHO DOES THE CLIENT USUALLY USE SUBSTANCES WITH? PLEASE CHECK THE BOX THAT APPLIES TO YOU BEST:

◯ ALONE
◯ ALWAYS ALONE
◯ MOSTLY ALONE
◯ ALONE AND WITH OTHERS
◯ WITH OTHERS
◯ ALWAYS WITH OTHERS
◯ MOSTLY WITH OTHERS

WHERE DOES THE CLIENT TEND TO USE SUBSTANCES? PLEASE INDICATE 'YES' OR 'NO' FOR EACH OF THE FOLLOWING:

LOCATION	YES	NO	LOCATION	YES	NO
AT HOME	◯	◯	ABANDONED VEHICLE	◯	◯
A FRIEND'S HOUSE	◯	◯	AT A PARTY	◯	◯
SCHOOL	◯	◯	OUTDOORS	◯	◯
ABANDONED BUILDING	◯	◯	OTHER:	◯	◯

HAS THE CLIENT EVER LOST FRIENDS DUE TO THEIR SUBSTANCE USE? ◯ YES ◯ NO

HAS THE CLIENT EVER GOTTEN INTO ANY PHYSICAL FIGHTS WHILE USING? ◯ YES ◯ NO

HAS THE CLIENT EVER CAUSED SERIOUS INJURY TO SELF OR OTHERS WHILE USING? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

DOES THE CLIENT HAVE ANY MEDICAL, PSYCHOLOGICAL, OR EMOTIONAL PROBLEMS DUE TO THE USE OF SUBSTANCES?

◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

DOES THE CLIENT FEEL THAT THEY HAVE CONTROL OVER THEIR USE OF SUBSTANCES? ◯ YES ◯ NO

HAS THE CLIENT EVER CONSIDERED REDUCING OR QUITTING THE USE OF SUBSTANCES? ◯ YES ◯ NO

HAS THE CLIENT BEEN IN PREVIOUS TREATMENT FOR THEIR USE OF SUBSTANCES? ◯ YES ◯ NO

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

_____

WHAT WOULD THE CLIENT LIKE TO FOCUS ON WHILE IN TREATMENT? _____

_____

PLEASE IDENTIFY SOME OF THE CLIENT'S STRENGTHS OR THINGS THEY DO WELL: _____

_____

J. PSYCHOLOGICAL FUNCTIONING

HAS THE CLIENT EVER SPOKEN OR WRITTEN ABOUT KILLING THEMSELVES? ◯ YES ◯ NO

HAS THE CLIENT EVER ATTEMPTED TO KILL THEMSELVES? ◯ YES ◯ NO

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

HOW DID THEY ATTEMPT TO KILL THEMSELVES? _____

HAS THE CLIENT FREQUENTLY GONE OFF ON THEIR OWN WHEN THEY ARE DEPRESSED OR UNHAPPY? ◯ YES ◯ NO

IS THE CLIENT CURRENTLY SAD OR UNHAPPY? ◯ YES ◯ NO

IF YES, HOW OFTEN? ◯ SOME OF THE TIME ◯ MOST OF THE TIME ◯ ALL OF THE TIME

HAS THE CLIENT EVER TAKEN PART IN SELF-MUTILATION OR SELF-HARMING BEHAVIOURS? IF YES, PLEASE EXPLAIN:

_____

DOES THE CLIENT HAVE DIFFICULTLY WITH ANGER? IF YES, PLEASE EXPLAIN: _____

_____

DOES THE CLIENT REQUIRE BEHAVIOURAL MANAGEMENT? IF YES, PLEASE EXPLAIN: _____

_____

HAS THE CLIENT EVER DEMONSTRATED CRUELTY TO ANIMALS? IF YES, PLEASE EXPLAIN: _____

_____

DOES THE CLIENT HAVE A HISTORY OF AGGRESSION TOWARDS OTHERS? IF YES, PLEASE EXPLAIN: _____

_____

DOES THE CLIENT HAVE A HISTORY OF FIRE SETTING? IF YES, PLEASE EXPLAIN: _____

_____

DOES THE CLIENT 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

IF YOU ANSWERED YES TO ANY OF THE 3 ABOVE QUESTIONS, PLEASE PROVIDE DETAILS (i.e., at what age, has it been reported and what was the outcome or current status?): _____

_____

IS THERE ANY HISTORY OF FAMILY VIOLENCE THAT THE CLIENT MAY HAVE BEEN WITNESS TO? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

_____

HAS THERE BEEN ANY SIGNIFICANT LOSSES IN THE CLIENT'S LIFE? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

_____

HAS THE CLIENT EVER RECEIVED ASSISTANCE TO DEAL WITH THE LOSSE(S)? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

_____

HAS YOUR CLIENT EVER HAD ANY PSYCHOLOGICAL TESTING OR COUNSELLING? ◯ YES ◯ NO

IF YES, FOR WHAT PURPOSE? _____

_____

Please attach any psychological / mental health assessment(s) conducted to-date (i.e., psycho-educational, SASSI, MAST, DAST, etc.) on the client which support the application to treatment.

DOES THE CLIENT HAVE A BED-WETTING PROBLEM ◯ YES ◯ NO

HAS THE CLIENT EVER RUN AWAY FROM HOME? ◯ YES ◯ NO

PLEASE INDICATE WHETHER THE CLIENT HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS:

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…

HAS THE CLIENT COMMUNICATED WITH SPIRITS NO ONE ELSE CAN SEE OR HEAR? ◯ YES ◯ NO

ARE THESE ENCOUNTERS POSITIVE OR NEGATIVE EXPERIENCES FOR THE CLIENT? PROVIDE DETAILS: _____

_____

ARE THERE TIMES WHEN PEOPLE ARE UNABLE TO COMMUNICATE WITH THE CLIENT? ◯ YES ◯ NO

IF YES, HOW OFTEN DOES THIS OCCUR? ◯ SOMETIMES ◯ OFTEN

PLEASE EXPLAIN: _____

K. OUTSIDE RESOURCES / FAMILY

ARE THERE ANY OTHER AGENCIES INVOLVED WITH THE CLIENT AND THEIR FAMILY? ◯ YES ◯ NO

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

_____

FAMILY ACTIVITIES / PRACTICES: WHAT ACTIVITIES DOES THE FAMILY DO TOGETHER? _____

_____

FAMILY ROLES / RELATIONSHIPS: HOW DOES THE CLIENT'S FAMILY INTERACT WITH EACH OTHER? _____

_____

STATUS IN THE COMMUNITY: HOW IS THE FAMILY PERCEIVED IN THE COMMUNITY? _____

_____

HOW DOES THE CLIENT SPEND THEIR LEISURE TIME? _____

WHO ARE THE OTHER SUPPORT PEOPLE INVOLVED WITH THE FAMILY? (i.e., elders, extended family, community groups, community workers, NNADAP, etc.)? _____

IS THE CLIENT AWARE OF THE EFFECTS OF SUBSTANCE USE? ◯ YES ◯ NO

IS THE FAMILY AWARE OF THE EFFECTS OF SUBSTANCE USE? ◯ YES ◯ NO

DOES THE FAMILY BELIEVE THE CLIENT RECOGNIZES THAT THEY HAVE A PROBLEM? ◯ YES ◯ NO

WHAT STEPS DOES THE FAMILY WANT TO TAKE TO ADDRESS THE PROBLEM? _____

_____

HAS ANYONE IN THE CLIENT'S FAMILY OR COMMUNITY RECEIVED TREATMENT FOR SUBSTANCE USE? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

ARE THE PARENT(S) SUPPORTIVE OF THE CLIENT RECEIVING TREATMENT? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

IS THE CLIENT AN INTERGENERATIONAL RESIDENTIAL SCHOOL SURVIVOR (IRSS)? ◯ YES ◯ NO

UPON THE CLIENT'S COMPLETION OF THE PROGRAM, WHAT TYPE OF SUPPORT SYSTEM DO YOU SEE AS EFFECTIVE / USEFUL TO HELP MAINTAIN A CLEAN LIFESTYLE? _____

_____

ARE THE EXTENDED FAMILY MEMBERS SUPPORTIVE OF THE FAMILY SEEKING HELP AND/OR TREATMENT FOR THE CLIENT?

◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

WOULD THE FAMILY BE WILLING TO COME TO THE TREATMENT CENTRE TO OBSERVE THE PROGRAM IN ACTION AS PART OF THE INTAKE PROCESS? ◯ YES ◯ NO

PLANS FOR REUNIFICATION - PLEASE EXPLAIN YOUR PLAN FOR REUNIFICATION INTO THE COMMUNITY ONCE TREATMENT IS COMPLETED, PROVIDE DETAILS:

Please submit all completed admission forms to the Intake & Continuous Care Facilitator, Samantha Birnie at the following:

- **Email:** sbirnie@kanachihih.ca
  OR
- **Fax:** +1 (807) 789-9803

L. WORKERS RECOMMENDATIONS

UPON COMPLETION OF THE TREATMENT PROGRAM, WHAT OTHER SUPPORTS ARE AVAILABLE TO THE CLIENT IN THEIR COMMUNITY?

NAME OF AGENCY / RESOURCE PERSON	DESCRIPTION OF SUPPORT	CONTACT INFORMATION

PLEASE INDICATE WHAT AREAS OF HEALING YOUR CLIENT FEELS WE SHOULD CONCENTRATE ON?

IS THERE ANY ADDITIONAL INFORMATION THAT YOUR CLIENT OR THEIR FAMILY FEELS MIGHT CONTRIBUTE TO THEIR TREATMENT?

WHAT IS YOUR ASSESSMENT OF THE CLIENT'S READINESS AND MOTIVATION TO ATTEND RESIDENTIAL TREATMENT?

ARE THERE ANY ADDITIONAL ISSUES THAT WE NEED TO BE AWARE OF?

PART 2 – MEDICAL ASSESSMENT

To be completed by a Physician / Nurse Practitioner prior to admittance into the treatment program OR (72) hours after arrival to the Healing Lodge.

Please complete this section in a CLEAR manner.

PATIENT'S NAME: _____

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

ONTARIO HEALTH CARD #: _____ STATUS CARD #: _____

DATE OF EXAM: _____

A. MEDICAL HISTORY (Please explain any 'YES' responses in the section provided below)

History of:	YES	History of:	YES	History of:	YES
Anemia	☐	Fainting	☐	Seizures	☐
Anxiety	☐	Hallucinations / Delusions	☐	Self-Harm (cutting/burning)	☐
Back Injury / Problem(s)	☐	Head Injury	☐	Skin Conditions	☐
Blood Transfusion	☐	Hearing Problems	☐	Suicidal Ideation	☐
Brain Injury	☐	Heart Murmur	☐	Suicide Attempt(s)	☐
Chicken Pox	☐	Hepatitis (A, B or C), please indicate:	☐	Surgery, please list: > >	☐
Depression	☐	High Blood Pressure	☐	Tobacco Use	☐
Disease / Injury of Bones or Joints	☐	Injection Drug User	☐	Tuberculosis	☐
Ear, Nose, Throat Problems	☐	Kidney Problems	☐	Urinary Tract Infection	☐
Eating Disorders	☐	Learning Disability	☐	Other:	☐
Eye Problems	☐	Liver Problems	☐	Other:	☐

B. PHYSICAL EXAMINATION

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

Please indicate if the following areas listed below are observed to be 'normal' or 'average' during the physical examination:

AREA	AVERAGE	AREA	AVERAGE
Cardiovascular	☐	Musculoskeletal System	☐
Cognition	☐	Neuropsychiatry	☐
Ears, Nose, Throat (system review)	☐	Lymph Nodes	☐
Eyes	☐	Respiratory	☐
Hygiene (standard)	☐	Skin	☐
Mental Health	☐	Tuberculosis (TB) Skin Test Result	☐

If 'YES' was indicated for any areas in **Section A** or any areas during the physical examination were observed to be 'abnormal' or 'atypical' in **Section B**, please explain:

C. CURRENT 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 Physician: For the client's safety and well-being while at the Healing Lodge, please ensure that they bring enough of their medications (in the original packaging from the doctor or pharmacist) for their time in treatment (3 months).

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?

◯ YES (1st shot only) ◯ YES (2 shots only) ◯ YES (2 shots plus booster(s)) ◯ NO

IS THE PROOF OF VACCINATION ATTACHED TO THE ADMISSION FORM? ◯ YES ◯ NO

PHYSICIAN'S NAME (print): _____ DATE: _____

ADDRESS: _____

MUNICIPALITY: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

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

PHONE: _____ FAX: _____

PHYSICIAN'S SIGNATURE: _____

CLIENT CONSENT TO RELEASE INFORMATION

I hereby authorize the above-named physician to release the information to the appropriate Healing Lodge, Intake Coordinator, as required, to assess my suitability for acceptance and admittance into the treatment program.

_____ _____

PARENT/LEGAL GUARDIAN/CLIENT SIGNATURE DATE

Please submit all completed admission forms to the Intake & Continuous Care Facilitator, Samantha Birnie at the following:

- **Email:** sbirnie@kanachihih.ca
  OR
- **Fax:** +1 (807) 789-9803