APPLICATION FOR ADMISSION FORM – PART A

January 2023

APPLICATION REQUIREMENTS

1. Must be 18 years of age or older
2. Must be free of withdrawals and the acute effects of drugs and/or alcohol; if detoxification is required, a referral to a Withdrawal Management Unit must be arranged prior to admission
3. Medical Physician or Nursing Practitioner must complete, sign and stamp the medical assessment – Part B
4. Must have current and valid Health Numbers on the application form

ADMISSION CRITERIA

1. All legal, medical, educational, employment, and childcare services must be dealt with prior to admission so as not to interfere with your treatment program
2. Remain alcohol free for a minimum of 72 hours (3 days) prior to admission; and a minimum of 14 days for psychoactive drugs, such as meth, cocaine, crack cocaine, Ritalin, opioids, benzodiazepines, and barbiturates.

PLEASE NOTE: *ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS.*

A. GENERAL INFORMATION

Date Application Received by Community Worker	Date Application Received by Treatment Centre

Surname:	Given Names:	Alias or also known as:

Date of Birth: mm/dd/yyyy	Age:	Gender Identity:	Primary Ph: Secondary Ph: For Messages:______________________

Mailing Address: ☐ No Fixed Address	Provincial Heath Card Number: 6 digit:____________________ 9 digit:____________________

Email Address:	Permission to contact by email: ☐ Yes ☐ No

Languages Spoken:	Languages Understood:	Languages Preferred:

Emergency Contact Name:	Telephone:	Relationship:

☐Status	☐ Non-Status	☐ Métis	☐ Inuit	☐ Other

Band Name:	Status Number:
☐ On Reserve:	☐ Off Reserve:
Grade Level Achieved: (✓ one box only)	Employment Status: (✓ one box only)

☐Gr 1-6	☐Gr 7-9	☐Gr 10-12	☐ Employed	☐ Unemployed
☐Gr 12 Diploma or GED	☐Some Post-Secondary		☐Disability	☐Student
☐College Certificate/Diploma	☐University Degree		☐ EIA / SA	☐ EI / Disability Leave

Ability to read / write in English: ☐ Yes ☐No ☐Needs assistance

B. FAMILY / RELATIONSHIPS

Marital Status: ☐ Single ☐ Common-law ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Does client have dependent children?	☐Yes ☐No	
If yes, do they have access to adequate childcare while in treatment?	☐Yes ☐No ☐Not Applicable	Details:
Are the children in care?	☐Yes ☐No ☐Not Applicable	Details:

Family Supports:
☐ Parents ☐ Spouse ☐ Grandparents ☐ Extended Family (Cousins, in-laws, aunts, uncles, etc) ☐ Friends ☐ Colleagues
☐ Other: ___________________________

Family Strengths:
☐ Showing affection ☐ Open communication ☐ Support each other ☐ Respect individuality ☐ Give compliments to each other
☐ Sharing feelings ☐ Spending quality time with each other ☐ Eating meals together ☐ Family gatherings
☐ Able to depend on each other ☐ Sharing what we have ☐ Humor ☐ Playfulness ☐ Comfort each other ☐ Strong connections

Personal Strengths:
☐ Kind ☐ Respectful ☐ Creative ☐ Trustworthy ☐ Hardworking ☐ Good with children ☐ Responsible ☐ Leadership skills ☐ Work well with others ☐ Forgiving ☐ Knowledgeable about the Land ☐ Confident ☐ Dedicated ☐ Focused ☐ Good sense of humor ☐ Know and speak my language

C. LEGAL HISTORY

Has client been court ordered to attend treatment?	☐Yes ☐No
If yes, provide details (include details/copy of Probation/Court Order or court dates, if applicable and/or available):	
Is the client under any of the following legal conditions?	☐Bail ☐Parole ☐Temporary Absence Order ☐Probation Order

Contact information of Probation / Parole / Justice Worker:
Name: ___________________________ Address: ___________________________
Contact No: (______)___________________________ Fax No:_(______)___________________________

D. TREATMENT HISTORY

Has client participated in a non-residential/community-based substance abuse program? e.g. NNADAP out-patient, Alcohol Anonymous, Cocaine Anonymous, etc.	☐Yes ☐No
Has client participated in a non-residential/community based mental health program? e.g. Anxiety Disorders Association of Manitoba (A.D.A.M), support groups, Therapy, Counseling, etc.	☐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:

E. 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	

F. PROCESS / BEHAVIOUR ADDICTIONS

Has client experienced problems with any of the following?

Process/Behavioral Addiction		Describe
Gambling (VLT's, poker, bingo, scratch tickets, betting, etc)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Eating (overeating, anorexia, bulimia, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Sex (promiscuity, pornography, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Internet / Social Media	☐Yes ☐No ☐Not Applicable ☐Unknown	
Gaming	☐Yes ☐No ☐Not Applicable ☐Unknown	

G. MENTAL HEALTH ISSUES

Provide the following information about the client's health status:

Mental Illness		Describe
Been diagnosed with a mental illness (ex. Anxiety, depression, bipolar disorder, psychosis, mood disorder, borderline personality disorder, post-traumatic stress disorder, prolonged grief disorder)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently being treated	☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently on psychiatric medication	☐Yes ☐No ☐Not Applicable ☐Unknown	
Taking medication as prescribed	☐Yes ☐No ☐Not Applicable ☐Unknown	

Suicidal thoughts / ideations	☐Yes ☐No	If yes, when was the last time?
Previous suicide attempts	☐Yes ☐No ☐Not Applicable ☐Unknown	If yes, when was the last time?
Hospitalized for suicide attempts	☐Yes ☐No ☐Not Applicable ☐Unknown	If yes, when?
Currently suicidal	☐Yes ☐No ☐Not Applicable ☐Unknown	
Name of psychiatrist /psychologist/ mental health worker (if applicable):	Client is encouraged to continue meeting with their Mental Health Worker during the program via Telehealth. What are the dates and times of appointments?	

NB: Client should not have any recent or active psychosis for a minimum of six weeks. Ensure client is compliant with their medication and willing to maintain contact with their mental health care provider. If there are behavioral issues such as angry outbursts, uncontrollable rage, or SPMI that is not being managed, client may be terminated from the program. In such an event, they are responsible for their own travel.

H. OTHER ISSUES / NEEDS

Are there any special needs we need to be aware of, eg, wheelchair, walking aids, speech, vision / hearing impairment, etc. If yes, please describe:	☐Yes ☐No
Does client understand there is an expectation of completion of a minimum of four counseling sessions prior to entering into a residential treatment?	☐Yes ☐No
Does client understand there is an expectation they must be alcohol and drug free for at least 3 days prior to admission to residential treatment, or 14 days if withdrawing from psychoactive drugs. Client with less than the required days *must* notify the treatment centre prior to admission.	☐Yes ☐No
Does client have cultural and/or spiritual beliefs and practices we need to be aware of? If yes, please describe:	☐Yes ☐No

I. 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 that if their travel has been covered to attend treatment, and is terminated by the Treatment Staff, or self-terminates from the program, they are responsible for their own travel costs. Further, that they will have to assume future costs to any medical appointments, and requires verification of attendance. *See Non-Insured Health Benefits Policy.*	☐Yes ☐No

J. 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 Treatment Centre.

Client's Signature:	**Date**
Referral Agent's Signature:	**Date**

K. REFERRAL AGENT'S INFORMATION

Referral Agent's Name:	Title:

Name of Agency:	Relationship to Applicant:		
Mailing Address:	Phone No:	Fax No:	Email Address:

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

Type of Referral (✓ the box which applies best):

☐ Treatment Centre	☐ Health / Medical Doctor	☐ Employer
☐ NNADAP	☐ Justice/ Courts	☐ Elder / Support Worker
☐ Mental Health	☐ Family Services	☐ Other:

Name/Resource	**Description of Support**

What is your assessment of the applicant's readiness and motivation for their participation in an 8-week residential treatment program?

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-4, MAST, DAST, DUSI, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. relationships with family, spouse, friends, impacts on school / work, Mental, Spiritual, Physical, and Emotional).

L. CLIENT'S STAGE (or READINESS) FOR CHANGE:

☐ Pre-contemplation: Not considering change; resistant to change
☐ Contemplation: Unsure of whether or not to change; chronic indecision
☐ Determination /Preparation: committed to changing behavior within one month
☐ Action: Begin changing behavior

Please list any questions or concerns the client has indicated during the intake process:

☐ Abandonment ☐ Residential School ☐Anger ☐Grief & Loss ☐ Parenting ☐ Sexual Abuse ☐ Rejection ☐ Suicidality ☐ Spiritual Crises ☐ Gambling ☐ Self-Harm ☐ Mental Health: Anxiety, Depression, Low Self Esteem, Fear, unresolved trauma

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, cross addiction, etc.):

Referral Agent's assessment of client's strengths and potential challenges for completing treatment:

M. Referral Checklist - Please initial each item that has been completed		
	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	
Client is aware that all medical, dental and optical appointments have to be dealt with prior to treatment	☐Yes ☐No	
Client is aware and understands that they *must* participate in <u>all</u> program activities including assigned chores, cultural/spiritual programming, and land-based activities:	☐Yes ☐No	
All legal matters have been dealt with prior to treatment:	☐Yes ☐No	
Referral Agent's Signature:	Date (MM/DD/YY):	

Tele-Health Site Availability: Should the client request visitation with family and or other supports during the program; is there a Tele-Health site available in your Community? □ Yes □ No

Nelson House MEDICINE LODGE
Mithwayawin Mitho Tehewinihk Ochi

Application for Treatment Medical Form -Part B

January 2023

This medical assessment is required as part of the application and must be <u>completed in full by a medical doctor.</u>
****Please note: We will not accept medical applications without the <u>client's name, date of birth, and health card number.</u>**

Patient Name (last, first, initial)	Date of Birth (YYYY-MM-DD)	Personal Health Care Number

Allergies (e.g.: drug, food, latex, other)	Special Dietary Requirements
Review of Systems *(please send relevant reports, e.g. CBC, Hepatic profile, electrolytes, urinalysis, etc.)*	
EENT	
Respiratory (e.g.: asthma, COPD)	Cardiovascular (e.g. CVA, MI, HTN, arrhythmia, pace-maker)
Gastrointestinal (e.g.: GERD, history of GI bleed, hepatitis, pancreatitis)	Genitourinary (e.g.: incontinence, BPH, STD)
Musculoskeletal (e.g.: chronic pain, RA, OA, gout)	Integumentary (e.g.: psoriasis, eczema)
Neurological: does the patient have history of seizures?	☐No ☐Yes
Hematological/Immune (e.g.: HIV+, HCV+)	Evidence of withdrawal or intoxication? (e.g.: ETOH, opioid)
Other (specify)	

Physical Examination

Height	Weight	Temperature	Pupils	Heart Rate	Blood Pressure	Respiration Rate

Skin	Diaphoresis	Tremor

Is the patient diabetic?	☐No	☐ Yes	Year Diagnosed?	Is the patient stable?	☐ No	☐ Yes

Does the patient have MRSA and wound?	☐ No	☐ Yes, (specify latest swab result):
Is there cognitive impairment?	☐ No	☐ Yes
Needs assistance ambulating or providing self-care?	☐ No	☐ Yes
When was the patient's last PAP smear?	What were the results?	

Pregnancy

Is the patient pregnant?	LMP		Para		Gravida
☐No, complete top boxes only →					
☐Yes, complete all boxes →	EDC	Urine HGC	Prenatal Blood Work	Prenatal ultrasound	Blood type

Does the patient have current pregnancy compilations or had a history of pregnancy complications?	
☐ No	☐ Yes, specify:

Physician managing the pregnancy and delivery	Phone:	Fax:
Address of planned location of delivery:		

Tb Screening-Symptoms and History		
Check the appropriate boxes	**No**	**Yes**
Presence of cough lasting more than 2 weeks		
Weight loss, if yes specify _______lbs. In ____ length of time		
Night sweats		
Fever		
Hemoptysis (blood in sputum)		
Previous active TB and treatment		
Previous significant Mantoux or chest x-ray results		
Extensive travel (or birth) in a country with high incidence of TB		
Other risk factors (e.g.: indigenous, elderly, homeless, health care worker)		
Poor general health status and risk factors for progress of disease		
Further TB screening/assessment required – if yes, please send results		

Medical Approval		
In your opinion is the patient medically stable and appropriate for admission to Residential Addiction Treatment? □No □Yes		
Physician's Name	**Signature**	**Date (YYYY-MM-DD)**

Psychiatric Review/History (please attach any psychiatric evaluations and/or discharge summaries (if available)		
Addictions – note date of last use, pattern of abuse and severity of addiction (e.g. alcohol, cocaine, opioids, cannabis, gambling, tobacco, etc.)		
Primary	Secondary	Tertiary

Is there evidence of the following? (please use your best judgment related to current severity of mental health concerns)	**No**	**Yes**	**Comments**
Mental development and/or learning disorders? (e.g. depression, anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)			
Underlying pervasive or personality conditions			
Acute medical conditions and physical disorders aggravating mental health (e.g. brain injury, cognitive impairment, chronic pain, insomnia)			
Contributing psychosocial and environmental factors			
Global Assessment of Functioning			
Is there a history of self-harm, suicidal thoughts, or suicide attempts? (If yes, pertinent psychiatric reports/assessments are required)			

Psychological Approval		
In your opinion is this patient psychologically stable and appropriate for admission to Residential Addiction Treatment? □No □ Yes		
Physician's Name	Signature	Date (YYYY-MM-DD)

Medications (if more room is needed, attach list)								
Medication	Dose	Rte	Frequency	Reason	Start Date	End Date	Prescribed By	Phone

Please remind client that in order to be admitted to the Medicine Lodge, they need to:

- Be well enough to participate in the program and remain alcohol and drug free for at least 72 hours prior to Admission.
- Please discuss any restricted medication at your initial appointment to avoid any delays in processing your application
- Ensure any new medications not listed above have been pre-approved by the Admissions department
- If you plan to discontinue any medication(s) we request so in writing by your physician
- If you receive an alternative medication(s) we request a new prescription list
- If the patient's medical or psychological condition changes before their scheduled admission date they must contact the Intake Worker.
- All medications must be bubble packed prior to entry into the Nelson House Medicine Lodge Treatment Centre.

Applicant's Name	**Signature**	**Date (YYYY-MM-DD)**
Physician's Name	**Signature**	**Date (YYYY-MM-DD)**

Mailing Address				
City/Town	Province	Postal Code	Phone:	Fax:
Primary Physician's Name (if different than above)			Phone:	Fax:
Other (e.g.: psychiatrist or other specialist relevant to this admission)			Phone:	Fax:

***Please ensure the medical portion is signed and stamped by the medical physician who completed the forms. Failure to do so may cause delays in processing your application.**	Physician's Stamp

Physician's Name (Print)	**Signature**	**Date (YYYY-MM-DD)**
Applicant's Name (Print)	**Signature**	**Date (YYYY-MM-DD)**

Please advise the applicant that the Nelson House Medicine Lodge Treatment Program is culturally based; Therefore, applicant will be expected to participate in ceremonies: Sweats, Smudging, and Fast Camps, etc.

Remind client to bring with them:

Toiletries:

- Towels, face cloths, soap, shampoo, toothpaste, toothbrush, comb, hairbrush, etc.

Sweat gear:

- Those who identify as females: cotton skirt must not go above the knee, t-shirt, robe, towel and slippers
- Those that identify as males: towel, cotton gym shorts, slippers and robe. **t-shirt may be required*

*****ALL CLIENTS MUST BRING THEIR PRESCRIBED MEDICATION IN BUBBLE PACKS*****

DO NOT BRING cellphones, tablets, or any other electronic devices. If found on their person, the items will be placed in a locked cabinet and returned to them upon their completion.

For the first 5 days in the program, clients must remain inbound. For those who smoke cigarettes, let them know they must bring enough to last them until they are permitted to go out and purchase cigarettes on their own free time.

Please fax in or email all 6 pages, along with Part B – Medical, completed and signed by client and referral agent.