Health Canada Santé Canada

ALBERTA REGIONAL NNADAP*

NNADAP Treatment Centres - Application Form

Canada

Treatment Centre - Please check one:

☐ Beaver Lake Wah-Pow Treatment Centre

☐ Footprints Healing Centre, Alexander

☐ Kapown Treatment Centre, Kapawe'no

☐ Mark Amy Treatment Centre, Fort McMurray

☐ St. Paul Treatment Centre, Standoff

Office use only - Treatment Centre

Registration date:____________________ Admission date:_____________________

Client file number:____________________ Cancellation date:___________________

PLEASE NOTE: All questions must be answered, otherwise form may be returned and process could be delayed

Part 1 - Client Application

A. General Information

Surname: ___________________________________ First Name(s):________________________________

Nickname or other name known by: Date of birth: (MM/DD/YY) Age:

____ _______________________ _________________

Gender: ☐ M ☐ F

Languages: spoken _________ preferred _________ understood _________

Status Indian: ☐ Yes ☐ No First Nation / Band Name:____

Treaty number (10-digit):________________________ Health insurance number:_______________________

Address (Home):______________________________ City: _______________________________________

____ Prov: _______________________________________

Tel.:____ Postal Code: __________________________________

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

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

Number of children and ages: ____

____

____

____

Do your children live with you? ☐ Yes, if not all how many ?________ ☐ No, Who are they with?___________

____

Do you have access to adequate childcare while in treatment? ☐ yes ☐ no

Child Welfare referred? ☐ yes ☐ no

Do you have any other dependents? ☐ yes ☐ no

Education level: Highest grade level completed: ______________________________
Post-secondary - Highest level achieved:__________________________________
Can you read and write? ☐ yes ☐ no

Legal status: ☐ Bail ☐ Parole ☐ Probation ☐ Temporary absence ☐ Court ordered
☐ Other_______________ Charges pending __________________ Court Dates ________________________

#1 Emergency Contact:

Name: ____________________________________ Relationship: __________________________________

Address:_____________________________________ Tel:____

____

#2 Emergency Contact:

Name:_______________________________________ Relationship:__________________________________

Address:_____________________________________ Tel:____

____

B. Substance Abuse Profile Date: (MM/DD/YY)_________________________

Substance use as of : Last use...
A: Within last 24 hours **B**: 2-7 days **C:** 8-30 days **D:** over 1 month **E**: over 1 year

☐ A - alcohol (e.g. beer, whiskey, cough syrup, mouthwash, aftershave,) ___________

☐ AN - antidepressants, paxil, zoloft, prozac ___________

☐ CA - cannabis, marijuana, hashish, hash oil ___________

☐ CM - crystal methamphetamine ________

☐ CO - cocaine, crack cocaine ________

☐ H - hallucinogens, angel dust, acid, peyote, magic mushrooms, ectasy, etc ________

☐ HE - heroin ________

☐ N - narcotics ________

☐ Prescription drugs: ________
 ☐ Opiates - Tylenol 3, T4, Morphine, Percocet, Oxycontin, etc
 ☐ Benzodiazepines - Ativan, Valium, Xanax, Serax, Mogadon, Librium, etc
 ☐ Other - Specify ________

☐ S - solvents / inhalants (e.g. gasoline, aerosols, paint thinner, glue, nail polish remover, rush, white out, hair spray, antifreeze) ________

☐ T - tobacco (e.g. cigarette, cigar, chewing tobacco) ________

☐ 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?		Type of Addiction
____	____	______________________________	☐ Yes	☐ No	______________________________
____	____	______________________________	☐ Yes	☐ No	______________________________
____	____	______________________________	☐ Yes	☐ No	______________________________

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

____

____

____

____

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

____

____

____

____

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

____

____

____

____

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

____

____

____

____

5. What I would like to learn about while in treatment is....

____

____

____

____

C - Other

- Are you allergic to any medication? ☐ No ☐ Yes, please specify:

____

- Are you allergic to any foods? ☐ No ☐ Yes, please specify:

____

- Any medical/dental concerns we should be aware of? ______________________________

____

- Do you wear dentures, partial plates, appliances? ☐ Yes ☐ No Do you wear a prosthesis? ☐ Yes ☐ No
- Do you have a pacemaker? ☐ Yes ☐ No

- When did you experience some of the withdrawal symptoms listed: (MM/DD/YY)

blackouts______________ DT's_________________ hallucinations_________ hangover_____________
nausea/vomiting_______ seizures_______________ shakes________________ dissociation___________
other________________

D - Mental Health Issues

1. Have you been diagnosed with a Mental Health Illness? (Eg: depression, bi-polar, schizophrenia) ☐ Yes ☐ No

If yes: When were you diagnosed____

What were you diagnosed with?____

What was/is the treatment? ____

___________________ ____

Are you currently being treated?________________Name of psychiatrist/psychologist _______________________

____

What current mental health medication are you on?____

Have you taken your medication consistently since being prescribed? □ Yes □ No If no, how long was the disruption period(s), please explain: ____

____

Are you on any medication that is required to be administered by a medical personnel? □ Yes □ No If yes, please explain: ____

____

2. Have you ever had suicidal ideation/thoughts? □ Yes □ No

If yes: Previous attempts:____

Were you hospitalized?____

Are you currently suicidal?____

Do you have a plan?: ____

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

Client 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?

____

____

____

____

- Stage of motivation and rediness for treatment:

____

____

____

☐ pre-contemplation
☐ Contemplation
☐ Determination
☐ Action

In order to be admitted to residential treatment, the applicant must remain alcohol and drug free for at least 7 days prior to their admission date, 14 days for patients using Benzodiazepines, and must be well enough to participate in the program.

☐ Have you had your four pre-treatment visits? ☐ Yes ☐ No

Dates:1.______________2.________________3.__________________4.___________

☐ 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 ☐ Yes ☐ No

*****Forward aftercare plan to centre if client has agreed to an aftercare plan*****

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

☐ S.A.S.S.I. ☐ Treatment Readiness ☐ Language Diagnostic ☐ Other

Why do you think this client wants treatment?

____

____

____

____

____

In your professional opinion, please give a detailed evaluation of how their addictions have affected their life in these areas? (Domestic, Medical, Social, Psychological, Spiritual, Emotional)

____

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____

Development of problem: ____

☐ Age when regular use began____

☐ Age when problems first began to occur____

☐ Gradual increase over a long time____

☐ Sudden rapid increase ____

☐ What was your primary use(s)?____

☐ Did a change occur? ☐ Yes ☐ No If yes, when?______________________________________

☐ And to what?____

☐ Any special circumstances surrounding the beginning of problem? _________________________

____

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

☐ Abandonment____

☐ Residential School ____

☐ 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:

____

____________________________ ____________________________
Referral 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): ______________________

Alberta Health Care Number:________________________________

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

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

B. **Please complete any yes responses from above in this section:**

____

____

____

____

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

____

C. TB Screening: Symptoms & History
If Yes, Date of Onset of the following:

Date of Onset	Yes	No		
________________	☐	☐	1.	Presence of cough lasting more than two weeks.
________________	☐	☐	2.	Weight Loss: _________ # of pounds: _____ Length of time:__________
________________	☐	☐	3.	Night sweats
________________	☐	☐	4.	Fever
________________	☐	☐	5.	Fatigue
________________	☐	☐	6.	Haempotysis (blood sputum)
________________	☐	☐	7.	Recent or past exposure to TB
________________	☐	☐	8.	Previous active TB and treatment
________________	☐	☐	9.	Previous significant Mantoux results or chest x-ray results
________________	☐	☐	10.	Correctional facility residence
________________	☐	☐	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.)?

____

____

____

____

____

____

*****Reminder to physician no mood altering medication allowed in residential treatment*****
(Unless medication is prescribed and monitored by a psychiatrist for management of a mental illness)

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 7 days prior to their admission date, 14 days for patients using Benzodiazepines, and must be well enough to participate in the program.

Are you the applicant's regular physician? ☐ Yes ☐ No

Physician's name: ______________________________ Date: ____

PRAC ID: ____________________________________

Physician's signature: ___________________________ Tel.: _______________ Fax: _____________________

Address:_____________________________________ City: ____

____ Postal Code: __________________________________

Physician's stamp:

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)

☐ Client has been notified and understands the **Non-Insured Health Benefits policy change** whereby anytime during treatment 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 Health Centre Transportation Coordinator or Health Canada.**

☐ 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 ($100 maximum)
- ☐ pyjamas and slippers
- ☐ personal items such as feminine hygiene

☐ Provincial health card(s) or photocopy of health card

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

______________________________	______________________________
Client 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 and child welfare 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 home after completion of the program	______
Informed that if at anytime during treatment the client self-terminates or the Treatment Centre terminates the client, and medical transportation has been provided, the client will have to assume the costs of the next trip to access medically required health service and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada **(New Policy)**	______
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	______

______________________________ ______________________________
Referral Signature Date