Carrier Sekani Family Services

# Ormond Lake Cultural Treatment Centre

# APPLICATION PACKAGE

This application package has four (4) parts that need to be completed:

- PART A – **Participant Information**; fill out this section with your personal information such as name, address, and more.
- PART B – **Referral Worker Information**; this section may be filled out by a NNADAP worker, a community health representative, or a mental health worker.
- PART C – **Participant Self-Assessment**; you and your referral worker can fill this part out together.
- PART D – **Pre-Admission Medical Information**; this section needs to be filled out by your doctor.

**Please note that all parts of this application package must be completed and received by the Addictions Recovery Program Intake Worker at least two (2) weeks before the start date of your treatment date.**

You may fax your completed application to our **confidential fax line at 250-567-2975.**
Only completed forms will be processed.

**If you do not have a referral worker, please contact our Addictions Recovery Program Intake Worker by calling 1-866-567-2333; they will help you find a referral worker.**

**Note:** *All the information you submit in this application package is private. Your participant files will be kept in a locked and secure location. To keep people safe, we may have to share information regarding self-harm, the harm of others, or child abuse*

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## PART A:

| | | |
|---|---|---|
| ○ **April 30th to May 27th, 2018** | ○ **June 2nd to 29th, 2018** | ○ **July 3rd – July 30th, 2018** |
| ○ **Aug. 3rd to 30th, 2018** | ○ **Sept. 4th to 30th, 2018** | ○ **Oct. 6th to 28th, 2018** |

## PARTICIPANT INFORMATION

**Note:** *Your application package must be received by the intake worker at least **two (2) weeks before the start date of the treatment program you want to attend**. All participants must not have used alcohol, drugs, or harmful substances for **Fourteen (14) days before attending**.*

Name:_____ Gender: ◯ M ◯ F

Birth:_____ Age:_____

Address:_____

_____

Phone:_____ Cell:_____

| | | |
|---|---|---|
| Marital Status: | ◯ Single | ◯ Common-law |
| | ◯ Married | ◯ Divorced |
| | ◯ Separated | ◯ Widowed |

| | | |
|---|---|---|
| Aboriginal: | ◯ Yes | ◯ No |
| Band Member: | ◯ Yes | ◯ No |
| On Reserve: | ◯ Yes | ◯ No |

Band Name:_____ Clan Name:_____

Status Number:_____

Emergency Contact:_____

Phone:_____ Cell:_____

Email:_____

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## PART B:
## REFERRAL WORKER INFORMATION

Referral Worker Name & Title:_____
Organization Name:_____
Organization Address:_____
Organization Phone:_____ Fax:_____

**Note:** *In order to qualify for Carrier Sekani Family Services Treatment Centre, the participant must have a minimum of six (6) one-hour pre-treatment counseling sessions with an alcohol and drug counselor, or a referral worker.*

Is the participant receiving counseling from you? ◯ Yes ◯ No

How many pre-treatment counseling sessions has the participant attended in the last three (3) months? _____

What issues has the participant worked on in these sessions? What is your perception of the participant's readiness for treatment?_____

_____

_____

What do you believe is Carrier Sekani Family Services Treatment Centre's role in the participant's overall treatment plan and their motivation for coming to treatment?_____

_____

_____

Has your participant engaged in additional healing programs, such as treatment centres, healing circles, cultural practices, physical activities, sports, journaling, self-help books, volunteer work, or other activities?

_____

_____

Do you have an after care plan with the participant? ◯ Yes ◯ No

Please explain:_____

_____


## PART C:

## PARTICIPANT ASSESSMENT – PHYSICAL

Are there any medical issues, physical mobility issues, or special needs that the Addictions Recovery Program staff need to be aware of? Do you have any infectious conditions, heart conditions, seizures, asthma, hepatitis, etc.?

_____

_____

_____

| | | |
|---|---|---|
| Can you walk up and down stairs by yourself? | ◯ Yes | ◯ No |
| Do you need mobility aids? | ◯ Yes | ◯ No |
| Do you need bathroom aids? | ◯ Yes | ◯ No |
| Do you need bathing aids? | ◯ Yes | ◯ No |
| Do you have any allergies? | ◯ Yes | ◯ No |
| Do you have an epi-pen? | ◯ Yes | ◯ No |

If you have allergies, please list them:_____

_____

Do you have any special dietary needs that we should be aware of? Are you diabetic, vegetarian, lactose intolerant, gluten intolerant, etc.?_____

_____

## PARTICIPANT ASSESSMENT – EMOTIONAL

What past or present emotional issues are you dealing with?_____

_____

_____

Do you feel ready and willing to participate in intensive group work? ◯ Yes ◯ No

Describe your experience in groups:_____

_____

_____

Do you have difficulty identifying or expressing emotions? ◯ Yes ◯ No


Please describe how you deal/express anger. For example, outbursts, yelling, storming out, throwing things, or withdrawing:_____

_____

_____

Do you have children in-care? ◯ Yes ◯ No

What key issues would you like to work on? Some ideas are: dealing with anger, grief, loss, depression, sexual abuse, low self-esteem, etc._____

_____

_____

## PARTICIPANT ASSESSMENT – SOCIAL

In your community, who do you go to for support?

| Support | Yes/No | Weekly? | Twice a Month? | Monthly? |
|---|---|---|---|---|
| Friend | | | | |
| Family | | | | |
| Religious Group | | | | |
| Cultural Group | | | | |
| Counsellor | | | | |
| Alcohol & Drug Worker | | | | |
| Community Health Rep | | | | |
| Peer Support Program | | | | |
| Medicine Person | | | | |
| AA or NA Meetings | | | | |
| Group Therapy | | | | |
| Elder's Support | | | | |
| Other | | | | |

Is this support working for you? ◯ Yes ◯ No

Explain why it does or does not meet your needs:_____

_____

_____


What are your living arrangements?

| | | |
|---|---|---|
| I live with my family | ◯ Yes | ◯ No |
| I live with friends. | ◯ Yes | ◯ No |
| I live with my extended family. | ◯ Yes | ◯ No |
| I live as part of a couple. | ◯ Yes | ◯ No |
| I live alone. | ◯ Yes | ◯ No |
| I live as a single parent. | ◯ Yes | ◯ No |
| I live with spouse and kids. | ◯ Yes | ◯ No |

What is the highest level of education you have completed?

◯ Elementary School (Grade_____)
◯ High School (Grade_____)
◯ College Diploma
◯ Trade School (culinary arts, carpentry)
◯ University Degree
◯ Graduate Degree

What is your current occupation?_____

◯ Full-time
◯ Part-time
◯ Full-time Seasonal
◯ Part-time/Seasonal
◯ Unemployed
◯ Homemaker
◯ Retired
◯ Not working due to disability
◯ Student

## PARTICIPANT ASSESSMENT – SPIRITUAL & CULTURAL

Are you willing to participate in First Nations treatment program components such as the sweat lodge, daily smudge, pipe and other cultural ceremonies? ◯ Yes ◯ No

Please identify any cultural and spiritual practices that help in your healing. For example, cultural events, native healers and self-healing practices._____

_____

_____

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## PARTICIPANT ASSESSMENT – MENTAL

Have you ever been diagnosed by a physician or psychiatrist for any mental illness?

◯ Bi-Polar ◯ Schizophrenia ◯ Depression

Other:_____

_____

What are you doing to stabilize this condition?

_____

_____

_____

Do you experience feelings of extreme sadness, depression, anxiety or panic attacks?

_____

_____

_____

Have you had trauma in the past that affects your well-being now?

_____

_____

_____

Have you ever attempted suicide? ◯ Yes ◯ No

If yes, when?_____

Have you had suicidal thoughts within the last twelve (12) months? ◯ Yes ◯ No

What is your current suicide risk factor?

◯ Non-existent ◯ Low ◯ Medium ◯ High

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## PARTICIPANT ASSESSMENT – LEGAL

Describe any pending or outstanding legal charges:

_____

_____

If applicable, list upcoming court dates:

_____

_____

Are you required by court order, probation, or the Ministry to attend a treatment program?

◯ No ◯ Yes

Are you on probation, Temporary absence or Parole?

◯ No ◯ Yes, complete below

Type of offence:

_____

Name of Parole/ probation officer

_____

Parole/ Probation officers phone number

_____

Parole/ probation officers agency/ office:

_____

Dates needed to be in contact with probation/ parole officer

_____

What other information might be important for your healing?

_____

_____

** *A copy of your probation order, including all conditions, must be included with this application for treatment, before the application can be processed.* **


## CONSENT TO ATTEND AND PARTICIPATE

I _____, consent to attend and participate at Carrier Sekani Family Services Treatment Centre. I have reviewed the following points with my referral worker and initialed as confirmation of my understanding of the following points:

_____ I understand that if I have not been free from alcohol and drugs for fourteen (14) days prior to attending, I will be immediately discharged from the program.

_____ I understand an incomplete application and lack of supporting documentation can cause delays in the processing of my application and confirmation of an intake date.

_____ I consent to the ARP Intake Worker or any other ARP counseling staff contacting referral agencies, such as CHR, NNADAP, CHN, Band Social Worker, Medical Practitioners, etc. to obtain clarification on information included in this application for treatment. If on provincial assistance, I agree the Intake Worker can release confirmation of my intake and discharge dates to my employment assistance worker.

_____ I understand the Intake Worker will notify my referral worker by letter to confirm my acceptance to treatment.

_____ While in treatment. I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.

_____ Upon arrival to the treatment centre I may be asked to submit to a supervised drug screening.

_____ I have reviewed and completed this application for treatment with my referral worker, answering all questions and providing all information truthfully and thoroughly to the best of my ability.

Name:_____

Signed:_____

Date:_____


## CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____, hereby give permission to the Addictions Recovery Program staff to contact the referral worker listed below for the release of information in regard to the pre-treatment conference call, progress during treatment, after care planning and the final discharge report.

Organization:_____

Referral Worker:_____

Worker Title:_____ Email:_____

Address:_____

_____

Phone & Fax:_____

Alternate referral contact:_____

The alternate contact person is for confirmation or admission processing only. The alternate contact person will not be included in the release of confidential information prior to, during, or after treatment.

The participant may change or revoke this release at any time by giving notice in writing to Addictions Recovery Program at Carrier Sekani Family Services.

**It is up to the participant to inform their referral worker of the change. This form will expire one (1) year after it is signed unless revoked.**

Participant Signature:_____

Witness Signature:_____

Witness Address:_____

_____

Day/Month/Year:_____


## PART D: PRE-ADMISSION MEDICAL ASSESSMENT

Participant Legal Name:_____

Also Known As:_____

Health Number:_____

Status Number:_____

Date of Birth:_____

Home Address:_____

_____

_____

Phone Number:_____ Cell:_____

**All Doctor Appointments/Specialist Appointments will need to be re-scheduled until after Treatment has been completed.**

**Signature:**_____

**Witness:**_____

## PARTICIPANT CONSENT

I, _____, hereby give my consent for Carrier Sekani Family Services Addictions Recovery Program to collect my medical information as a condition of attending Carrier Sekani Family Services Treatment Centre. I consent to my information being released by Dr._____ to the Carrier Sekani Family Services Treatment Centre.

Participant Signature:_____

Day/Month/Year:_____


## TO THE PHYSICIAN OR NURSE PRACTITIONER:

The aforementioned participant is to be medically assessed as a requirement for participation in a four (4) week treatment program at Carrier Sekani Family Services Treatment Centre for alcohol, drugs, or inhalant abuse or dependency. The Addictions Recovery Program requires each participant to have a complete physical examination prior to admission. Please include any relevant results from lab, operative reports or consultations including psychological or educational psychology reports. Activities that the participant may participate in during their stay at the centre include smudging ceremonies, sweat lodges, hiking, hunting, swimming and/or boating.

Participant Name:_____ Date of Birth:_____

Care Card Number:_____ Status Number:_____

Height:_____ Weight:_____ Blood Pressure:_____

Does the participant have any allergies? ◯ Yes ◯ No

If yes, please specify (Dietary, medication or Other Allergies):_____

_____

_____

Does the participant have an Epi-pen or Ana Kit? ◯ Yes ◯ No

**Note:** ***participants must have an epi-pen or bracelet if allergic to bees or nuts***

Is the participant pregnant? ◯ Yes ◯ No if yes, when is the due date?_____

**Note*****: Carrier Sekani Family Services Treatment Centre will only accept participants in their second trimester.***

Has the participant been tested for TB in the last twelve (12) months? ◯ Yes ◯ No

If yes, what were the results? ◯ Positive ◯ Negative

When was the date of the test?_____

**Note to the physician or nurse practitioner:** *Participants wishing to attend Carrier Sekani Family Services Treatment Centre must be tested for TB* ***PRIOR*** *to admittance to treatment. If there is a positive result, a chest x-ray is mandatory with a copy of the results to be faxed to the treatment centre.*

Is the participant on any medications? ◯ Yes ◯ No


Please print name of medication(s):

Describe the purpose of the medication:

If any prescribed medications are required during the participant's stay at the centre, please list and briefly describe instructions for the participant:

As a pre-requisite to alcohol and drug residential treatment, the patient must be free from all communicable diseases (scabies, lice, etc.) and have **fourteen (14) days** clean from alcohol and mood-altering drugs prior to admission to Carrier Sekani Family Services Treatment Centre.

| | | |
|---|---|---|
| Hepatitis: | Participant has been tested for | ◯ A ◯ B ◯ C |
| HIV/AIDS: | Participant has tested | ◯ Positive ◯ Negative |
| Does the participant have lice? | | ◯ Yes ◯ No |

Please provide details about the health functionality of the participant:

| | | |
|---|---|---|
| Blood/Lymphatic | ◯ Normal | ◯ Abnormal: |
| Cardiac | ◯ Normal | ◯ Abnormal: |
| CNS | ◯ Normal | ◯ Abnormal: |
| Ear/Nose/Throat | ◯ Normal | ◯ Abnormal: |
| Gastrointestinal | ◯ Normal | ◯ Abnormal: |
| Genito-Urinary | ◯ Normal | ◯ Abnormal: |
| Hair/Skin/Nails | ◯ Normal | ◯ Abnormal: |
| Musculoskeletal | ◯ Normal | ◯ Abnormal: |
| Respiratory | ◯ Normal | ◯ Abnormal: |

Please comment on any abnormalities in the functional or the physical examination:

Chronic Illness or Conditions:

◯ Arthritis ◯ Autism ◯ Brain Injury ◯ Cancer ◯ Chronic Fatigue Symptoms
◯ Epilepsy ◯ FASD ◯ Fibromyalgia ◯ Lupus ◯ Rheumatoid Arthritis


◯ ST/STI:_____

◯ Other:_____

Does this participant have a history of psychiatric disorders or clinical depression? Please comment:_____

_____

_____

_____

## DECLARATION OF FITNESS

I have examined the participant and find him/her to be fit to attend Carrier Sekani Family Services Treatment Centre.

◯ **Fit to Attend** ◯ **Unfit to Attend**

Signature:_____ Date:_____

Print Name:_____

Clinic Address:_____

_____

Thank you for helping our participant complete the application process to attend Carrier Sekani Family Services Treatment Centre. Please return this application to Carrier Sekani Family Services.

Carrier Sekani Family Services

# CONSENT FOR SERVICES & CONFIDENTIALITY AGREEMENT

**Our Goals:** The goal of Mental Health and Addictions (MH&A) is to provide counselling services that will respect your values and offer you a variety of approaches to improve the well-being of you/your family. In the process, you/your family have the right to the confidentiality of all the information you share with our staff, and the right to view all records that relate to you/your family.

**The Process:** In most cases, our staff will spend some sessions gathering information about your situation. After this, our staff will let you know what they think might help in your situation, and how this help might best be delivered to you and your family.* Your family/you have the right to know exactly what is happening at any time in the process, and where you are at in the process. Your participation is voluntary, and you may terminate your involvement at any time.

**The Records:** In order to view your records, a written request must be made to the Manager of this program (MH&A). Your records will be revealed to you once we are assured that all the people listed in the records are protected.

**Confidentiality:** We follow a confidentiality protocol; however, there are some times when we have to reveal the information in your records to other people. Here are some examples of when we have to tell others about your situation:

- If anyone expresses a desire of harming themselves or someone else, and our staff believe that there is a real danger of someone being harmed, we have to let the proper authorities know;
- If someone discloses that a child/youth (under the age of 19) is or has been physically, sexually, emotionally abused or neglected, we have to let others know;
- In rare cases a judge may ask to see your records for court purposes.

**Understanding:** It is important to us that you/your family members understand the reasons for anything that happens during the time we spend with you. We invite you to ask any questions about any issue at any time.

**By signing below, we/I agree that we/I understand the above issues and agree to participate in services.**
**Signed:**

**Parents / Guardians / Family Members / Individual(s)**

| Name | Signature |
|---|---|
| Name | Signature |
| Name | Signature |

**Date:**

**MH&A Clinician (name and signature)**

*We call this process Clinical Treatment. The first phase of Clinical Treatment is called Assessment and might involve answering various kinds of questions. After Assessment a Provisional Diagnosis is made. Diagnosis followed by the development of a written Treatment Plan.

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# ITEMS TO BRING To The Treatment Centre

- Bedding – Pillow, sheet, sleeping bag
- Hygiene – towel, face cloth, toiletries, (soap, toothbrush, paste), feminine hygiene supplies, sun screen
- Clothing – **enough for 28 days** – pants, shorts, shirts, underwear, pajamas, socks, sweaters, jacket, rain coat, and running shoes, swim wear, sweat wear (long night gown for women, shorts for men and sandals)
- Your own over-the-counter medication (such as Tylenol or extra strength Tylenol) **WE DO NOT PROVIDE THESE.**
- Flashlight and day pack
- If allergic to bees; your **OWN** EPI Pen
- Any **SAFE** medication prescribed by your physician. **MUST BE BLISTER PACKED**.
- Your **OWN** insect repellent
- A drum if you have one
- Smudge if you have some
- If you would like to listen to CD's please bring your own and you are also responsible for them as well.
- **CELL PHONES ARE NOT PERMITTED FOR THE DURATION OF THE FOUR WEEK TREATMENT CYCLE**


## APPLICATION CHECKLIST

- ◯ Completed Part A – Participant Information
- ◯ Completed Part B – Referral Worker Information
- ◯ Completed Part C – Participant Assessment
- ◯ Completed Part D – Pre-Admission Medical Assessment
- ◯ Signed the Consent to Attend and Participate
- ◯ Signed the Consent to Release Information
- ◯ Signed the Carrier Sekani Family Services Treatment Centre Rules
- ◯ Have you seen this participant prior to filling out this form?
- ◯ Is this participant 18 years of age or older?
- ◯ Will this participant be free of misuse of alcohol and drugs for two (2) weeks prior to admission?
- ◯ Is this participant able to identify at least two (2) peer supports in their community?
- ◯ Is this participant willing to attend, participate, and remain in the program each day?
- ◯ is this participant able to not disrupt group processes?
- ◯ Does this participant have childcare arrangements in place, if needed?
- ◯ Have you confirmed travel arrangements to and from Ormond Lake Cultural Treatment Centre?
- ◯ Does this participant have documentation for all their medications?
- ◯ Does this participant have all their medications in blister pack?

**Please note that all parts of this application package must be completed and received by the Addictions Recovery Program Intake Worker at least two (2) weeks before the start date of the treatment cycle.**

You may fax your completed application package to our confidential fax line at 250-567-2533.

Only completed forms will be processed.