

SASKATCHEWAN NNADAP TREATMENT SERVICES APPLICATION FORM

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VAN LOON  CONSULTING 

This application is the first step required to pre-screen applicants for adult treatment at any of the NNADAP facilities listed below. Additional information may be required by individual centers before a decision on acceptance is made.

In-Patient Treatment Centres – Please check one:

- | | |
|--|--|
| <p><input type="radio"/> Cree Nations Treatment Haven
Box 340, Canwood SK, S0J 0K0
Phone: [306] 468-2072
Fax: [306] 468-2758
Email: cree.nations@sasktel.net
Website: www.creenationstreatmenthaven.ca</p> <p><input type="radio"/> Mistahey Musqua
Box 404, Loon Lake, SK, S0M 1V0
Phone: [306] 837-2184
Fax: [306] 837-4414
Email: mistahey.musqua@sasktel.net</p> <p><input type="radio"/> Ekweskeet Healing Lodge
Box 280, Onion Lake, SK, S0M 2E0
Phone: [306] 344-2094/ 2380
Fax: [306] 344-4805
Email: ekweskeet@sasktel.net</p> | <p><input type="radio"/> Sakwatamo Lodge
Box 3917, Melfort, mSK, S0E 1A0
Phone: [306] 864-3631
Fax: [306] 864-2204
Email: sakwatamo@sasktel.net</p> <p><input type="radio"/> Armand Bekkata Treatment Centre
Box 5010, Clearwater R., SK, S0M 3H0
Phone: [306] 822-2033
Fax: [306] 822-2750
Email: crdntc@sasktel.net</p> |
|--|--|

Out-Patient Centres:

- | | |
|--|---|
| <p><input type="radio"/> Athabasca Outpatient Project
Box 162, Black Lake, SK, S0J 0H0
Phone: [306] 284-2124
Fax: [306] 284-2173</p> <p><input type="radio"/> Cree Nations Treatment Haven
MATRIX Outpatient Treatment Program
Box 340, Canwood, KK, S0J 0K0
Phone: [306] 468-2072
Fax: [306] 468-2758</p> | <p><input type="radio"/> Saulteaux Healing & Wellness Centre
Box 868, Kamsack, SK, S0A 1S0
Phone: [306] 542-4110
Fax: [306] 542-3241</p> |
|--|---|

Office use only – Treatment Centres

Registration Date: _____

Admission Date: _____

Actual admission date: _____

Cancellation date: _____

Part 1 – Client Application:

A. General Information

Surname: _____ First Name[s]: _____

Nickname: _____ Gender: Male Female Date of birth: _____

Status Indian: Yes No First Nation/Band Name: _____

Band Number: _____ Treaty Number: _____

Health Insurance Number: _____ Social Insurance Number: _____

Address [Home]: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Marital Status: Single Married Common law Widowed Divorced Separated

Family Type: Living alone With spouse With spouse & children With friends

Single parent with children With extended family

Number of children and ages: _____

Do your children live with you? Yes, if not all, how many? _____ No

Educational level: Grade 1 – 6 Grade 6 – 9 Grade 9 – 12 Post – secondary

Employment: Full-time job Part-time job Unemployed Seasonal work

Home maker Student

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax Number: _____ Email: _____

B. Substance Use Profile

Substances Used:

A: Last 24 hours B: 2-7 days C: 8-30 days D: Over one month E: Over one year

- | | | |
|---------------------------------------|--|--|
| <input type="radio"/> Alcohol | <input type="radio"/> Marijuana | <input type="radio"/> Crack Cocaine |
| <input type="radio"/> Cocaine | <input type="radio"/> Tobacco | <input type="radio"/> Ecstasy |
| <input type="radio"/> Crystal Meth. | <input type="radio"/> Heroin | <input type="radio"/> Talwin & Ritalin |
| <input type="radio"/> Antidepressants | <input type="radio"/> Prescription Drugs | <input type="radio"/> Hallucinogens |
| <input type="radio"/> Morphine | <input type="radio"/> Inhalants | |

Other: _____

Which is your drug of choice? _____

What is your pattern of use: Daily Weekly Binges Other: _____

Which of the following areas have been negatively affected by your use?

- School Attendance Family Relationships Physical Health Employment
 Psychological Health Legal Situation Other: _____

Is there any history of alcohol/drug use in your family of origin? Yes No

If yes, please explain: _____

Do you have any of the following "Process" Addictions?

- Gambling Relationship[s] Shopping Workaholic Sex Other _____

Are you now, or have you ever been an IV user? Yes No

As of today, when was your last use of any alcohol/drug? _____

What Type? _____ How much? _____

C. Social Profile

Have you attended treatment previously?		<input type="radio"/> Yes	<input type="radio"/> No	If yes, please explain:
Year	Dates	Name of Centre & Location	Completed?	Drug[s] treated for
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No	_____
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No	_____
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No	_____
In what way is your drinking or drug use a problem for you? _____				

What is the longest period you have been able to stay free of substances? _____				
What enabled you to remain free of substances at that time? _____				

Why are you seeking treatment at this time?				
<input type="radio"/> To get children back		<input type="radio"/> Court ordered	<input type="radio"/> Condition of employment	
<input type="radio"/> Family pressure		<input type="radio"/> Other: please explain: _____		

Do you have custody of any minor children?			<input type="radio"/> Yes	<input type="radio"/> No
What are the plans for your children while you are in treatment? _____				

What are your expectations of the treatment program? _____				

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

Social Profile Cont.

What are your behaviour patterns when you drink and/or use drugs?

Aggressive Argumentative Less Shy Quiet Outgoing Withdrawn

Other, please explain: _____

Have you ever been refused treatment or terminated from treatment? Yes No

If yes, please explain: _____

Did you or any member of your family attend residential school? Yes No

Please provide details: _____

Are you presently involved with any other agencies [i.e. Social Services, Probation Services, NNADAP, Outpatient Counselling, etc.], that may provide continued support to you when you have completed treatment?

Yes No

If yes, please list agencies?

May we involve these agencies in your case planning? Yes No

If yes, please provide contact information:

Agency	Contact name	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Legal History

Have you ever been convicted of a crime? Yes No

What was the outcome? Incarcerated Conditional Sentence Monitor

Probation Bail Temporary absence Other: _____

Were you under the influence of any substance[s] at the time of your offence?

Yes No If yes, please explain: _____

Do you have any charges pending or before the court at this time? Yes No

If yes, what are the charges: _____

When and where is your next court appearance? _____

What is your present legal status? Parole Probation Bail TA N/A

- *Note: You may be required to submit a formal list of past convictions prior to individual treatment centre acceptance.*

E. Medical History

Do you have any medical history of seizures, allergies, heart conditions, or diabetes?

Yes No If yes, explain: _____

Have you ever had any suicidal attempt or ideations? Yes No

If yes, please explain: _____

Have you ever undergone a Mental Health Assessment? Yes No

If yes, would you be willing to share a copy of the assessment with our center? Yes No

If yes, who provided the assessment and when? _____

If female, are you currently pregnant? Yes No Due date: _____

Have you used any alcohol or drugs during your pregnancy? Yes No

Are there any other medical concerns we should be aware of? If yes, please explain:

F. Referral Agent Questionnaire

Name: _____ Title: _____ Agency: _____

Address: _____ Phone: _____

How long have you been involved with this client? _____

In your opinion, what is motivating this client to seek treatment? _____

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

Abandonment Anger Grieving Sexual abuse

Parenting skills Rejection Residential School Other: _____

Are you aware of any factors in this client's life [medical/legal] that may pose a threat to other clients in treatment?

Yes No If yes, please explain: _____

Has this client been referred to and denied treatment at any other center?

Yes No If yes, please explain: _____

Will you continue to see the client once he/she has completed treatment? Yes No

Do you have any information or suspicion that this client may have difficulties due to Fetal Alcohol Spectrum Disorder [FASD]? Yes No

If yes, please explain: _____

Have you completed a SASSI or other format of addictions assessment? Yes No
If yes, please include a copy along with this application.

Do you require a discharge summary report? Yes No

Referral Agent Oath:

I certify that the information contained in this section is true to the best of my knowledge.

Signature: _____ Date: _____

G. Medical Form [must be completed by licensed physician]

Patient First Name: _____ Last Name: _____ Initials _____

Patient Date of Birth: _____ Hospitalization Number: _____

Physician Name: _____ Phone Number: _____

Please check yes or no to indicate if client is currently being treated for or if they have a history of any of the following:

	YES	NO	PLEASE PROVIDE DATES AND DETAILS
<u>Tuberculosis</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Heart Disease</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Mental Illness</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Epilepsy</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Seizures – other than Epilepsy</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>High Blood Pressure</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Cancer</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Allergy</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Stroke</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Diabetes</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Back Pain</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Venereal Disease</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Emphysema or other Lung Disease</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>HIV/AIDS</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Hepatitis A B C</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Scabies</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Lice</u>	<input type="radio"/>	<input type="radio"/>	_____
<u>Pregnancy</u>	<input type="radio"/>	<input type="radio"/>	LPM / / / Live Births: _____ D M Y
<u>Special Diet</u>	<input type="radio"/>	<input type="radio"/>	_____
CURRENT MEDICATIONS	DOSAGE	REASONS/COMMENTS	
_____	<input type="text"/>	_____	
_____	<input type="text"/>	_____	
_____	<input type="text"/>	_____	

Note: Please attach any further information that you think may be of benefit to the treatment centre.

Doctor's Signature: _____ Date: _____

By signing this form I give authorization for any medical information to be released by the physician

Client Signature: _____ Date: _____