# 2021 Inpatient Treatment Application

**Cree Nations Treatment Haven**

**Box 340**

**Canwood, SK**

**S0J 0K0**

**Phone: 1-306-468-2072**

**Fax: 1-306-468-2758**

**Fax completed application**

**Phone if you have any questions or concerns**

## A. Personal Information

Last Name: ___________________________ First Name(s) _____________________ D.O.B. ________________

Nickname: ___________________________ Self-Identified Gender: ( ) Male ( ) Female ( ) Other

Status Indian: ( ) Yes ( ) No First Nation/Band: _______________________ Live On Reserve: ( ) Yes ( ) No

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 Partner ( ) With Partner & Children ( ) With Friends

( ) Single Parent with Children ( ) With Extended Family

Number of children & ages: ______________________ Child & Family Services involved: ( ) Yes ( ) No

Are you mandated to treatment by court or child family services: ( ) Yes ( ) No

Do your children live with you: ( ) Yes, if not all, how many? _________________________ ( ) No

Education Level: ( ) Grade Completed _____ ( ) High School Diploma ( ) Trade School

( ) Post-Secondary

Difficulty Reading & Writing: ( ) Yes ( ) No Learning Difficulties: ( ) Yes ( ) No

Employment: ( ) Full-Time Job ( ) Part-Time Job ( ) Unemployed ( ) Seasonal Work

( ) Home Maker ( ) Student

Residential School Attendance: ( ) Yes ( ) No If yes, how long? ___________________________________

Did you have a family member attend residential school? ( ) Yes ( ) No

If yes, please explain: ____________________________________________________________________________

__________________________________________________________________________________________________

Do you require a wheel chair accessible room: ( ) Yes ( ) No If yes, please explain: ______________________

Do you have any physical limitations CNTH needs to be aware of: ( ) Yes ( ) No

Please explain: ____________________________________________________________________________________

**Emergency Contact**

Name: _______________________________________ Relationship: ______________________________

Address: __________________________________________________________________________________

Home Phone: _______________________________ Work Phone: ______________________________

Cellphone: __________________________________

## B. Substance Use Profile

Alcohol and/or drugs misuse is considered to be misuse if you have tried any of the following more than two times in order for the mood-altering effect. **Please put a circle around the primary drug(s) of choice – the substance causing you the must difficulty in your life.**

| Type | Age Of First Use | How Often Used | Amount | Method Of Use | Date Of Last Use |
|---|---|---|---|---|---|
| ALCOHOL | | | | | |
| CANNABIS | | | | | |
| COCAINE | | | | | |
| HALLUCINOGEN | | | | | |
| BARBITURATE | | | | | |
| AMPHETAMINE | | | | | |
| HEROIN | | | | | |
| OPIATE | | | | | |
| INHALANT | | | | | |
| ILLICIT METHADONE | | | | | |
| BENZODIAZEPINE | | | | | |
| OVER THE COUNTER DRUGS | | | | | |
| OTHER PRESCRIPTION DRUGS | | | | | |
| TOBACCO | | | | | |
| OTHER | | | | | |

**IMPORTANT NOTE FOR ADMISSION CRITERIA**

**APPLICANT MUST HAVE 3 FULL DAYS CLEAN FROM ALCOHOL AND DRUGS PRIOR TO ADMISSION TO TREATMENT. NO EXCEPTIONS. APPLICANTS WILL BE DRUG TESTED UPON ADMISSION. IF TESTED POSITIVE, THE APPLICANT WILL BE DECLINED ACCEPTANCE INTO THE PROGRAM.**

## B. Substance Use Profile Continued

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

( ) School Attendance ( ) Family Relationships ( ) Physical Health ( ) Employment

( ) Legal ( ) Mental Health ( ) Housing ( ) Financial

( ) Leisure Time ( ) Other: ________________________

Is there a history of substance misuse/abuse in your family of origin? ( ) Yes ( ) No

If yes, please explain: ______________________________________________________________________

Do you have any of the following process addictions: ( ) Gambling ( ) Relationships ( ) Shopping ( ) Sex

( ) Work ( ) Other: __________________________

## C. Social Profile

Have you attended treatment previously? ( ) Yes ( ) No

| Date | Name of Centre & Location | Completed | Substance Treated For |
|---|---|---|---|
| ____________ | _____________________________ | ( ) Yes ( ) No | _______________________ |
| ____________ | _____________________________ | ( ) Yes ( ) No | _______________________ |
| ____________ | _____________________________ | ( ) Yes ( ) No | _______________________ |

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

If yes, please explain: _______________________________________________________________________

Have you ever attended: ( ) Alcoholics Anonymous ( ) Narcotics Anonymous

( ) Other 12 Step Programs ( ) Other: ______________________________

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 helped you to remain free of substances at that time? __________________________________________

_________________________________________________________________________________________

What is your motivation for going to treatment?

( ) To get children back ( ) Court ordered ( ) Condition of employment

( ) Family pressure ( ) Help yourself ( ) Other: ______________________

Do you have custody of any minor children? ( ) Yes ( ) No

What are the plans for your children while you are in treatment? _______________________________________

## C. Social Profile Continued

What are your expectations/goals of the treatment program? ________________________________________

______________________________________________________________________________________

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

______________________________________________________________________________________

______________________________________________________________________________________

## D. Legal History

Have you ever been convicted of a crime? ( ) Yes ( ) No

What was the outcome? ( ) Incarceration ( ) 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

Name of probation officer: ______________________________ Phone Number: _____________________

**Important Note For Admission Criteria**

- **Attach legal papers (probation order, CSO, ect.) to application.**
- **The applicant must not have any upcoming legal issues or court dates. ALL court dates must be dealt with prior to admission. Court date interference with treatment may result in dismissal from the program until resolved.**
- **An applicant may be required to submit a formal list of past convictions prior to admission.**
- **Cree Nations Treatment Haven does not accept charged or convicted sex offenders.**

## E. Case Planning

Are you presently involved with any other agencies (social services, probation services, NNADAP, child & family services, outpatient counselling) that may provide continued support to you when you have completed treatment? ( ) Yes ( ) No

If yes, please list the agencies Cree Nations Treatment Haven has your permission to involve in your case planning:

| **Agency** | **Contact Name** | **Phone Number** |
|---|---|---|
| ______________________________ | ____________________________ | ____________________ |
| ______________________________ | ____________________________ | ____________________ |

## F. 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: _______________________________________________________________________

Is suicide a concern? ( ) Yes ( ) No If yes, what is the level of risk: ______________________________

**If within the past twelve (12) months, please attach a Suicide Risk Assessment to your application**

Have you ever undergone a Mental Health Assessment? ( ) Yes ( ) No

If yes, who provided the assessment and when? ________________________________________________

**If yes, please attach a copy to your application**

**Check All Boxes That Apply**

( ) Trauma/PTSD ( ) Depression ( ) Anxiety/Panic Disorder ( ) Brain Injury

( ) ADD/ADHD ( ) FAS/FAE ( ) Anger/Acting Out ( ) Family Trauma

( ) Grief & Loss ( ) Schizophrenia ( ) Drug-Induced Psychosis ( ) Suicide Attempts

( ) Suicide Ideation ( ) Other Mental Health Disorder

Please provide a brief explanation: __________________________________________________________

_____________________________________________________________________________________

Are you currently pregnant? ( ) Yes ( ) No Due date: ______________________________

Have you been tested for COVID – 19: ( ) Yes ( ) No ***Please attach the lab results**

Are there any other medical concerns CNTH should be aware of? ( ) Yes ( ) No

If yes, please explain: _______________________________________________________________________

**<u>Important Note For Admission Criteria</u>**

- **Schizophrenia or drug-induced psychosis requires a mental health assessment**
- **Complete the medical form attached to application (section I)**

## G. Referral Agent Assessment – **Leave Blank if Self-Referred**

Name: ______________________________ Title: ______________________ Agency: ____________

Address: __________________________________________ Phone: ___________________________

How long have you been involved with this applicant? ___________________________________________

In your opinion, what is motivating the applicant to seek treatment? __________________________________

Where is the applicant in the Stages of Change? ( ) Pre-contemplation ( ) Contemplation

( ) Preparation ( ) Action ( ) Maintenance

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

________________________________________________________________________________

________________________________________________________________________________

Are you aware of any factors in the applicant's life [medical/legal] that may pose a threat to other

applicants in treatment? ( ) Yes ( ) No If yes, please explain:_________________________________

Has this applicant been referred to and denied treatment at any other center? ( ) Yes ( ) No

If yes, please explain: ___________________________________________________________________

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

If yes, please describe follow-up plans: _____________________________________________________

________________________________________________________________________________

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:___________________________

## Important Note For Admission Criteria

**The applicant will be contacted via telephone by a counsellor prior to acceptance into the program. The purpose of this conversation is to discuss further questions or concerns the applicant or counsellor has.**

## H. Consent To Attend And Participate In Treatment

I, (please print applicant's name) ______________________________________consent to attend and participate at CNTH and I have reviewed the following points with my referral worker and initialed as confirmation of my understanding of the following points.

1. _______ I understand that if I do not have 3 full days free from alcohol and drugs, I will be immediately discharged from the program.

2. _______ I understand an incomplete application and lack of supporting documentation delays the processing of my application and confirmation of an intake date.

3. _______ I give permission to the intake coordinator and nurse to contact referral agencies, such as probation officers, medical practitioners, to obtain clarification on information included in this application for treatment. If on Income Assistance, I agree the intake coordinator can release confirmation of my intake and discharge dates to my Employment and Assistance Worker and First Nations Health.

4. _______I understand if I have legal issues, a copy of the probation order must be submitted with my application for treatment, and ALL pending court dates must be dealt with prior to admission to CNTH. I understand any court date interference may result in my being dismissed until resolved.

5. _______I understand the intake coordinator will notify my referral worker by letter to confirm my acceptance to treatment.

6. _______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.

7. _______ I understand the importance of being free from and have taken care of all outside business, which will take my attention away from the treatment program.

8. _______ I understand if I am discharged or voluntarily leave treatment that Social Assistance and First Nations Inuit Health Branch will not cover my return travel and that I am responsible for return travel. I will be arriving at treatment with my return travel arrangements in place.

9. _______ 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.

## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

10. _______ If accepted, I consent for the counsellor to confer with my probation officer, if applicable, regarding my progress and clarifying any details.

11. I, (please print applicant's name) ________________________________hereby give permission for CNTH staff to contact the referral worker(s) listed below for the release of information in regard to a pre-treatment conference call and progress during treatment, aftercare planning and Final Discharge Summary.

Referral Worker's Signature: ____________________________________________ Date: ________________

Applicant's Signature: __________________________________________________ Date: ________________

NOTE: The alternate contact person is for confirmation or admission processing only – the alternate contact will not be included in the release of confidential information prior to, during or after treatment. The applicant may change or revoke this release at any time by giving notice to Cree Nation Treatment Haven in writing. It is up to the applicant to inform their referral worker of the change. This form is applicable for one year after the date signed unless revoked.

## I. 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 |
|---|---|---|---|
| Tuberculosis | O | O | |
| Heart Disease | O | O | |
| Mental Illness | O | O | |
| Epilepsy | O | O | |
| Seizures – other than Epilepsy | O | O | |
| High Blood Pressure | O | O | |
| Cancer | O | O | |
| Allergy | O | O | |
| Stroke | O | O | |
| Diabetes | O | O | |
| Back Pain | O | O | |
| Venereal Disease | O | O | |
| Emphysema or other Lung Disease | O | O | |
| HIV/AIDS | O | O | |
| Hepatitis A B C | O | O | |
| Scabies | O | O | |
| Lice | O | O | |
| Pregnancy | O | O | LPM / / / Live Births:<br>D M Y |
| Special Diet | O | O | |

| CURRENT MEDICATIONS | DOSAGE | REASONS/COMMENTS |
|---|---|---|
| | | |
| | | |
| | | |

**<u>IMPORTANT NOTE FOR ADMISSION CRITERIA</u>:**

- **The applicant's medications are required to be blister packed.**
- **After receiving confirmation of the applicant's acceptance to CNTH, it is <u>mandatory</u> the applicant's physician or nurse practitioner faxes the original prescription(s) to Prince Albert Medi-Centre Pharmacy (fax: 306-764-0602) for a medication supply for the duration of the program.**
- **Applicant is required to submit a negative COVID – 19 test result prior to admission into treatment. The date of test taken can be no later than two weeks prior to intake date.**

## I. Medical Form Continued

- **Please list admission diagnosis with a brief history of present active medical conditions**
- **Provisions for any follow-up treatments or care required while in treatment at CNTH? Please specify**
- **Any pertinent physical exam findings? Please specify.**

Physician/Nurse Practitioner Name: ___________________________________________________________

Address: ________________________________________________________________________________

Telephone: ________________________________________ Fax: _______________________________________

______________________________________

Physician Nurse Practitioner Signature

______________________

Date

Office Stamp

**NOTE: Please ensure you have read and reviewed the Safe/Unsafe Medication List on page 12. Non-compliance with said list will result in the applicant not being accepted into CNTH.**

## J. Safe/Unsafe Medication List

<table>
<tr><th>UNSAFE</th><th>SAFE</th></tr>
<tr><td>
Avoid pain medications that contain Opiates (e.g. Codeine):
<ul>
<li>Tylenol 1, 2, 3 or 4 (all Opioids)</li>
<li>Demerol</li>
<li>Percocet</li>
<li>Fiorinal Plan ¼ or ½</li>
<li>Levo-Dromoran</li>
<li>222, 282, 292, 692, Darvon (Propoxyphene)</li>
<li>Talwin</li>
<li>Percodan</li>
<li>Leritine</li>
<li>Dilaudid</li>
<li>Nabilone</li>
<li>Gabapentin</li>
</ul>
Avoid Nerve and Sleeping Pills including:
<ul>
<li>Librium</li>
<li>Tranxene</li>
<li>Serax</li>
<li>Xanax</li>
<li>Others used for anxiety/nervousness/ tranquilizer</li>
<li>All Benzodiazepines</li>
</ul>
Avoid CNS Stimulants such as Methamphetamines:
<ul>
<li>Dextroamphetamine (Dexedrine)</li>
<li>Lisdexamphetamine</li>
</ul>
Avoid Sleeping Pills including these and others:
<ul>
<li>Dalmane</li>
<li>Halcion</li>
<li>Restoril</li>
<li>Tuinal</li>
<li>Seconal</li>
<li>Zopiclone (Imovane)</li>
</ul>
Avoid Muscle Relaxants:
<ul>
<li>Robaxisal</li>
<li>Robaxacet</li>
<li>Parafon</li>
<li>Flexeril</li>
</ul>
Over the Counter Medications can be a Serious Threat:
<ul>
<li>Cough syrups contain alcohol, codeine and antihistamines. These are all drugs which need to be avoided.</li>
</ul>
Avoid Sedating Antihistamines such as:
<ul>
<li>Gravol</li>
<li>Actifed</li>
<li>Dimetap</li>
<li>Chlortriplon</li>
<li>Benydryl or products containing diphenhydramine</li>
</ul>
</td><td>
Pain Medications:
<ul>
<li>ASA or Aspirin</li>
<li>Advil or Ibuprofen</li>
<li>Midol</li>
</ul>
Available Only by Prescription:
<ul>
<li>Tryptan</li>
<li>Buspirone (Buspar)</li>
<li>Toradol</li>
<li>Possible other prescription medications – please contact Resident Nurse for clarification</li>
</ul>
Antidepressants Safe with Proper Use and by Prescription Only:
<ul>
<li>Elavil</li>
<li>Citalopram</li>
<li>Morex</li>
<li>Serzone</li>
<li>Desipramine</li>
<li>Effexor (Venlafaxine)</li>
<li>Zoloft (Sertraline)</li>
<li>Prozac (Fluoxetine)</li>
<li>Luvox (Fluvoxamine)</li>
<li>Paxil (Paroxetine)</li>
<li>Trazodone (Desyrel)</li>
<li>Mirtazapine</li>
<li>Buproprion</li>
<li>Seroquel (Quetiapine)</li>
</ul>
Migraines:
<ul>
<li>Imitrex</li>
</ul>
Non-Sedating Antihistamines:
<ul>
<li>Seldane</li>
<li>Claritin</li>
<li>Hismanil</li>
</ul>
Sleep Aids:
<ul>
<li>Epsom Salt</li>
<li>Melatonin</li>
<li>Calcium (333mg) Magnesium (167mg) with VD3 (5mcg)</li>
<li>Lavender Oil</li>
</ul>
</td></tr>
</table>

**Note:** This is a partial list. If you require more information, please ask the doctor or pharmacist about non-psycho active/mood-altering medications.