35 DAY TREATMENT PROGRAM APPLICATION FORM

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.

Please check one:

In-Patient Treatment Program:

☐ 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.creenationsreatmenthaven.ca

Out-Patient Treatment Program:

☐ Cree Nations Treatment Haven
   MATRIX Outpatient Treatment Program
   Box 340, Canwood, SK, S0J 0K0
   Phone: [306] 468-2072
   Fax: [306] 468-2758

Office use only – Treatment Centres

Registration Date: __________________________

Admission Date: __________________________

Actual admission date: __________________________

Cancellation date: __________________________
35 DAY TREATMENT PROGRAM APPLICATION FORM

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: __________________________

2
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

- ☐ Alcohol
- ☐ Marijuana
- ☐ Crack Cocaine
- ☐ Cocaine
- ☐ Tobacco
- ☐ Ecstasy
- ☐ Crystal Meth.
- ☐ Heroin
- ☐ Talwin & Ritalin
- ☐ Antidepressants
- ☐ Prescription Drugs
- ☐ Hallucinogens
- ☐ Cocaine
- ☐ Tobacco
- ☐ Ecstasy
- ☐ Crystal Meth.
- ☐ Heroin
- ☐ Talwin & Ritalin
- ☐ Antidepressants
- ☐ Prescription Drugs
- ☐ Hallucinogens
- ☐ Morphine
- ☐ 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?**
- [ ] Yes
- [ ] No

If yes, please explain:

<table>
<thead>
<tr>
<th>Year</th>
<th>Dates</th>
<th>Name of Centre &amp; Location</th>
<th>Completed?</th>
<th>Drug[s] treated for</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] Yes</td>
<td>[ ] No</td>
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<tr>
<td></td>
<td></td>
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<td>[ ] Yes</td>
<td>[ ] No</td>
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<td></td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

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?**
- [ ] To get children back
- [ ] Court ordered
- [ ] Condition of employment
- [ ] Family pressure
- [ ] Other: please explain: ________________________________

______________________________

**Do you have custody of any minor children?**
- [ ] Yes
- [ ] 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:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Contact name</th>
<th>Phone Number</th>
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</thead>
<tbody>
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</tbody>
</table>
### D. Legal History

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been convicted of a crime?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>What was the outcome?</td>
<td>Incarcerated, Conditional Sentence, Monitor, Probation, Bail, Temporary absence, Other:</td>
</tr>
<tr>
<td>Were you under the influence of any substance[s] at the time of your offence?</td>
<td>Yes, No, If yes, please explain:</td>
</tr>
<tr>
<td>Do you have any charges pending or before the court at this time?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>If yes, what are the charges?</td>
<td></td>
</tr>
<tr>
<td>When and where is your next court appearance?</td>
<td></td>
</tr>
<tr>
<td>What is your present legal status?</td>
<td>Parole, Probation, Bail, TA, N/A</td>
</tr>
</tbody>
</table>

*Note: You may be required to submit a formal list of past convictions prior to Cree Nations Treatment Haven acceptance.*

### E. Medical History

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any medical history of seizures, allergies, heart conditions, or diabetes?</td>
<td>Yes, No, If yes, explain:</td>
</tr>
<tr>
<td>Have you ever had any suicidal attempt or ideations?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>No</td>
<td></td>
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<tr>
<td>If yes, please explain:</td>
<td></td>
</tr>
<tr>
<td>Have you ever undergone a Mental Health Assessment?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>No If yes, would you be willing to share a copy of the assessment with our center?</td>
<td>Yes</td>
</tr>
<tr>
<td>No If yes, who provided the assessment and when?</td>
<td></td>
</tr>
<tr>
<td>If female, are you currently pregnant?</td>
<td>Yes, No, Due date:</td>
</tr>
<tr>
<td>Have you used any alcohol or drugs during your pregnancy?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Are there any other medical concerns we should be aware of?</td>
<td>If yes, please explain:</td>
</tr>
</tbody>
</table>
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(PRINT): ___________________________ 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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>PLEASE PROVIDE DATES AND DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Mental Illness</td>
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<tr>
<td>Epilepsy</td>
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<tr>
<td>Seizures – other than Epilepsy</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Cancer</td>
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<td>Allergy</td>
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<td>Stroke</td>
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<tr>
<td>Diabetes</td>
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<td>Back Pain</td>
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<tr>
<td>Venereal Disease</td>
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<tr>
<td>Emphysema or other Lung Disease</td>
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<tr>
<td>HIV/AIDS</td>
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<td>Hepatitis A B C</td>
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<tr>
<td>Scabies</td>
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<td>Lice</td>
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<tr>
<td>Pregnancy</td>
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<td>LPM / / / Live Births: D M Y</td>
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<tr>
<td>Special Diet</td>
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</table>

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: ___________________________