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

Please 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: _____ Date of last ideation/attempt: _____

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	( ) Bi-Polar	( ) Other Mental Health Disorder	

Please provide a brief explanation: _____

If you have experienced drug-induced psychosis, date of last symptom(s): _____

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: _____

Important Note For Admission Criteria

- **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: _____

Email or Fax Number: _____

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 or referral will be contacted via telephone by a counsellor or intake worker prior to acceptance into the program. The purpose of this conversation is to discuss further questions or concerns the applicant or counsellor and intake worker have.

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	○	○	
Heart Disease	○	○	
Mental Illness	○	○	
Epilepsy	○	○	
Seizures – other than Epilepsy	○	○	
High Blood Pressure	○	○	
Cancer	○	○	
Allergy	○	○	
Stroke	○	○	
Diabetes	○	○	
Back Pain	○	○	
Venereal Disease	○	○	
Emphysema or other Lung Disease	○	○	
HIV/AIDS	○	○	
Hepatitis A B C	○	○	
Scabies	○	○	
Lice	○	○	
Pregnancy	○	○	LPM / / / Live Births: D M Y
Special Diet	○	○	

CURRENT MEDICATIONS	DOSAGE	REASONS/COMMENTS

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

- **The applicant's medications are required to be blister packed.**
- **If applicant's medication list changes prior to intake, send CNTH an update list.**
- **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

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

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

K. Treatment Readiness Inventory – To be completed by applicant

Instructions: Read each statement, then mark the box whether you AGREE or DISAGREE with the statement as it applies to you personally at this time. Mark each statement truthfully. There are no right or wrong answers. Do not make any guesses. **MARK EACH STATEMENT ONLY ONCE, BUT BE SURE YOU MARK EVERY STATEMENT.**

Agree	Disagree	
		1. I do not have a problem with drinking/drug use
		2. I know I drink/use too much.
		3. I will quit drinking/using only when I am good and ready.
		4. I do have a problem with my drinking/ using.
		5. I must quit drinking/using once and for all.
		6. People talk about my drinking/using.
		7. I have my drinking/using under control
		8. People can help me with my drinking/using problems.
		9. I do not want anyone telling me what to do about my drinking/using.
		10. I can quit drinking using whenever I want.
		11. I need help now for my drinking/using problems.
		12. My family worries about my drinking using.
		13. I do not care who knows I am getting help for my problems with drinking/using.
		14. People have good reason to talk about my drinking/using.
		15. My drinking/using causes problems in my life.
		16. No one is going to force me to quit drinking/using.
		17. I need to talk honestly with other people about my drinking/using.
		18. People have no reason to talk about my drinking/using.
		19. I do not care who knows I am getting help for my problems with drinking/using.
		20. There are times I had to cut down my drinking/using.
		21. I cannot control my drinking/using any more.
		22. There is no need for me to stop drinking using.
		23. I am going to stop my drinking/using no matter what it takes.
		24. I must do something about my drinking/using problems now, or they will only get worse.
		25. What I do about my drinking/using is nobody's business.

Treatment Readiness Inventory – Scoring Form

Instructions For Scoring

Name: _____ Age: _____ Male: _____ Female: _____

1. Draw a line through the number if it is marked AGREE on the inventory. DO NOT draw any line the number is marked DISAGREE on the inventory.

Denial	**Awareness**	**Resistance**	**Acceptance**	**Readiness**
1.	2.	3.	4.	5.
7.	6.	9.	8.	11.
10.	12.	13.	14.	17.
18.	15.	16.	21.	19.
22.	20.	25.	24.	23.
_____	_____	_____	_____	_____

2. Count the marks and write the total between 0-5 in each space below the headings.
3. Then…
   a. Add the totals scores for Awareness + Acceptance + Readiness. Put the total here _____
   b. Add the total scores for Denial + Resistance. Put the total here _____
4. To obtain the Treatment Readiness (T-R) score:
   a. Find your total for Awareness + Acceptance + Readiness in the top line from the chart below.
   b. Find your total for Denial + Resistance in the left column.
   c. The number where the two totals meet is your T-R score. Enter this score here _____
   d.

	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
0/1	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
2	7.5	7	6.5	6	5.5	5	4.5	4	3.5	3	2.5	2	1.5	1	0.5
3	5	4.7	4.3	4	3.7	3.3	3	2.7	2.3	2	1.7	1.3	1	0.7	0.3
4	3.8	3.5	3.3	3	2.8	2.5	2.3	2	1.8	1.5	1.3	1	0.8	0.5	0.3
5	3	2.8	2.6	2.4	2.2	2	1.8	1.6	1.4	1.2	1	0.8	0.6	0.4	0.2
6	2.5	2.3	2.2	2	1.8	1.7	1.5	1.3	1.2	1	0.8	0.7	0.5	0.3	0.2
7	2.1	2	1.9	1.7	1.6	1.4	1.3	1.1	1	0.9	0.7	0.6	0.4	0.3	0.1
8	1.9	1.8	1.6	1.5	1.4	1.3	1.1	1	0.9	0.8	0.6	0.5	0.4	0.3	0.1
9	1.7	1.6	1.4	1.3	1.2	1.1	1	0.9	0.8	0.7	0.6	0.4	0.3	0.2	0.1
10	1.5	1.4	1.3	1.2	1.1	1	0.9	0.8	0.7	0.6	0.5	0.4	0.3	0.2	0.1

L. Treatment Information

All rooms are double occupancy.

Medication
All prescribed medications and unopened supplements will be locked up in the medication cabinet at all times. We have scheduled times for the applicant to take medication. Over the counter medication and vitamins with broken seals are not allowed.

What To Bring

- Personal hygiene items (shampoo, soap, tooth brush, toothpaste, shaving kit, etc)
- Journal
- Recovery-related reading material
- Gym shoes (non-marking) and workout clothes
- Comfortable, modest clothing
- Socks and underwear
- Season appropriate outerwear
- Small day pack
- Sufficient prescription medicine and in the original containers or bubble wrapped for the duration of your treatment (see section H of application)
- Debit/credit card or cash
- Enough cigarettes for your entire stay (for smokers) or sufficient funds to purchase locally
- Personal health care number and other valid identifications

What Not To Bring

- Offensive, revealing, or inappropriate clothing (anything promoting drugs or alcohol, gang affiliation, sex, violence)
- Scented products (perfume, lotion, cream)
- Hair dye
- Aerosol containers (hairspray, body spray)
- Products containing alcohol (check labels)
- Electronics or personal entertainment items
- Food
- Cameras
- Sex toys, pornography
- Work and education course material
- Weapons, knives, scissors
- Previously opened over-the-counter medication, vitamins, herbals and/or supplements

Incidental Money
Applicants will need funds for prescribed medications if the medication is not covered through health insurance. Also, the applicant is responsible to bring money for canteen, cigarettes, or personal hygiene items.

Reading Material
Only recovery-related reading material is allowed at CNTH and will be reviewed by primary counsellor for appropriateness.

Laundry
Laundry facilities and products are available for applicants.