PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED
INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS.
Form to be completed by referring agent.
Attach a separate sheet of paper if more room is needed.

VIRTUAL WELLNESS REFERRAL APPLICATION

GENERAL INFORMATION

Surname:	First Name:	Middle Name:	Nickname/AKA:
Date of Birth:	Age:	Sex:	Provincial Heath Card Number
Address:			Telephone:
Email Address of client so that we can send a link to join ZOOM			
Language Spoken:	Language Preferred:		Language Understood:
Emergency Contact Name:		Telephone:	Relationship to client:
Status Indian: Y N	Treaty/Band Number:		Band Name:
Education:	Literacy Level:	Employment Status:	
Family Supports:			
Family Strengths:			

LEGAL STATUS

Has client been court ordered to attend a treatment program?	☐Yes ☐No	
*If **YES**, provide details (include details/copy of Probation Order if applicable and/or available):*		
Most Recent involvement in the justice system at entry:	☐ Criminal Court ☐ Family Court ☐ Drug Court Treatment ☐ Probation ☐ Charges Pending	☐ Court Referral ☐ Court Order ☐ Restorative Justice ☐ Mental Health ☐ No Involvement ☐ Unknown
Is the client under any of the following legal conditions?	☐Bail ☐Parole	☐Temporary Absence Order
Other (provide details, dates, etc.):		
Does this client have any previous charges/convictions?	☐Yes ☐No	

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If yes, provide details:	

TREATMENT HISTORY

Had client participated in a **non-residential**/community-based substance abuse program, such as Outpatient, or Day program?	☐Yes	☐No
Had client participated in a **non-residential**/community-based substance mental health program?	☐Yes	☐No
If yes, what type of program(s):		
Has client participated in an **in-patient** residential treatment program before?	☐Yes	☐No

If yes, please provide information on previous treatment experience:

YEAR	TREATMENT CENTRE	TYPE OF ADDICTION	COMPLETED		COMMENTS
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	

Reason(s) for currently requesting treatment:

PROCESS/BEHAVIORAL ADDICTIONS

HAS CLIENT EXPERIENCED PROBLEMS WITH ANY OF THE FOLLOWING? Please Check all that apply

☐ Gambling	☐ Eating	☐ Sex	☐Internet or texting	☐Gaming	☐Social Media	☐On-line shopping

MENTAL HEALTH ISSUES

Provide the following information about the client's health status:

Mental Illness		Describe		
Previous suicide attempts	☐Yes	☐No	☐Not Applicable	☐Unknown
If yes, when?				

Hospitalized for suicide attempts	☐Yes	☐No	☐Not Applicable	☐Unknown
If yes, when?				
Currently suicidal	☐Yes	☐No	☐Not Applicable	☐Unknown
Name of psychiatrist/psychologist (if applicable):				

E. OTHER ISSUES/NEEDS

Are there any other significant issues we need to be aware of? If yes, please describe:	☐Yes ☐No
If yes, please describe:	

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Personal Strengths:

F. APPLICATION CHECKLIST	
Client Authorization	
I authorize the documentation of my information for this application to be used with the AMIS data base. I understand and agree to accept the terms described to me by the Treatment Centre.	
Client Signature	**Date**
Referral Signature	**Date**

REFERRAL INFORMATION		
Will you continue to see the client once he/she has completed treatment?	☐Yes	☐No
What other supports would be available to your client in their community upon completion of treatment?		
Name/Resource	**Description of Support**	

Client's Stage of Readiness:
☐Pre-contemplation - Not considering change; resistant to change ☐Contemplation - Unsure of whether or not to change; chronic indecision ☐Determination - Preparation; committed to changing behavior within one month ☐Action - Begin changing behavior ☐Maintenance - Behavior change has persisted for 6 months or more
Please list any questions or concerns the client has indicated during the application process:
What other areas might need to be addressed during program? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):
Referral Agent assessment of client's strengths and potential challenges for completing treatment:

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Clients Name: _____

REFERRAL CHECKLIST			
Please initial which applicable items have been completed. Check off any items attached to this application:			
Item	**Attached**		**Initials**
Psychiatric evaluations	☐Yes	☐No	
Probation order	☐Yes	☐No	
Assessment Summary **(DUSI-R) See attached short form**	☐Yes	☐No	

PLEASE INITIAL EACH ITEM THAT HAS BEEN COMPLETED:	
Item	**Initials**
Client Has access to internet and a form of electronic communication (ie. Tablet, cell phone, computer)	
If no, are you (the referral agent) willing to take full responsibility for our property should we provide your client with this technology (Tablet) For example, gets damaged, broken, stolen? And will you explain this to the client.	
Explain to the client that this device must be returned to us in the same condition that they received it. In other words, this is not their personal device and that they would not be downloading any apps. Or lend it to anyone.	
Replacement would be in monetary amount or complete replacement	
Can you say that this person can participate in the session with safety in mind and should he/she need immediate assistance, will you be available at any given time.	
Can you provide a 24/7 number that we would call so someone would go and help the client when in a crisis situation?	

Referral Signature & contact number	Date (M/D/YY)

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