



# ORT

**NO WEEKEND PASSES DURING THIS PROGRAM**

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED  
INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS.

Form to be completed by referring agent.  
If any information is NOT APPLICABLE = NA,  
UNKNOWN = UNK and  
UNAVAILABLE = UNA.

Attach a separate sheet of paper if more room is needed.

## ADULT INTAKE/REFERRAL APPLICATION

<u>GENERAL INFORMATION</u>									
Surname:	First Name:	Middle Name:	Nickname/AKA:						
Date of Birth:	Age:	Sex:	Provincial Health Card Number						
Address:			Telephone:						
Language Spoken:	Language Preferred:	Language Understood:							
Emergency Contact Name:		Telephone:	Relationship to client:						
Status Indian:    Y    N	Treaty/Band Number:		Band Name:						
	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>								
Education:	Literacy Level:	Employment Status:							
<u>FAMILY / RELATIONSHIPS</u>									
Marital Status:									
Does Client have dependent children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable						
If yes, do they have access to adequate childcare while in treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable						
Are the children in care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable						
Does the client have other dependents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable						
Provide information on client's children or other dependents:									
Name	Age	Relationship							

### RISING SUN TREATMENT CENTER

31 Riverview Rd. W., Eel Ground First Nation, NB. PH#: 506-627-4626 / FAX#: 506-627-4627

Father's Name:	Deceased?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Community:
Mother's Name	Deceased?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Community:
Family Supports:			
Family Strengths:			

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

<b><u>TREATMENT HISTORY</u></b>				
Had client participated in a <b>non-residential</b> /community-based substance abuse program, such as Outpatient, or Day program?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had client participated in a <b>non-residential</b> /community-based substance mental health program?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what type of program(s):				
Has client participated in an <b>in-patient</b> residential treatment program before?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If yes, please provide information on previous treatment experience:</b>				
YEAR	TREATMENT CENTRE	TYPE OF ADDICTION	COMPLETED	COMMENTS
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Reason(s) for currently requesting treatment:

**WITHDRAWAL SYMPTOMS**

Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptoms		Describe
Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Shakes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Delirium Tremens (DT's)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Ever experienced DTs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

<b>PROCESS/BEHAVIORAL ADDICTIONS</b>		
HAS CLIENT EXPERIENCED PROBLEMS WITH ANY OF THE FOLLOWING?		
Process/Behavioral Addiction		Describe
Gambling (slots, cards, Keno, bingo, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Eating (obesity, anorexia, bulimia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Sex (promiscuity, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Internet/texting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Gaming	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Social Media	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

<b><u>MENTAL HEALTH ISSUES</u></b>				
Provide the following information about the client's health status:				
<b>Mental Illness</b>	<b>Describe</b>			
Been diagnosed with a mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Currently being treated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Currently on psychiatric medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Taking medication consistently	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Previous suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	If yes, when?		
Hospitalized for suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
If yes, when?				
Currently suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Unknown
Name of psychiatrist/psychologist (if applicable):				
<b><u>E. OTHER ISSUES/NEEDS</u></b>				
Does client have cultural and/or spiritual beliefs and practices we need to be aware of?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:				
Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe:				<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please describe:	
Are there any other significant issues we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:	
Does client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does client understand there is an expectation they have been alcohol and drug free for at least 7 days prior to admission to residential treatment (or 14 days if withdrawing from benzodiazepines). (Client with less than the required days must notify the treatment centre prior to admission).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Strengths:	

<b><u>F. APPLICATION CHECKLIST</u></b>	
Confirmation of transportation to Treatment Centre through referral	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confirmation of transportation back home	<input type="checkbox"/> Yes <input type="checkbox"/> No
Client has been notified and understands the Non-Insured Health Benefits policy change whereby anytime during treatment and the client self-terminates, or the Treatment Centre terminates the client, and medical transportation benefits have been provided, the client will have to assume the costs of the next trip to access medically required health services and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Client Authorization</b>	
I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by the Treatment Centre.	
<b>Client Signature</b>	<b>Date</b>
<b>Referral Signature &amp; Contact Information</b>	<b>Date</b>

<b>REFERRAL INFORMATION</b>						
Has the client completed four pre-treatment appointments?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please provide appointment dates:		Date 1:	Date 2:	Date 3:	Date 4:	
Will you continue to see the client once he/she has completed treatment?						<input type="checkbox"/> Yes <input type="checkbox"/> No
What other supports would be available to your client in their community upon completion of treatment?						
Name/Resource	Description of Support					
<b>PRESENT LIVING SITUATIONS:</b>						
<input type="checkbox"/> Lives Alone, own place	<input type="checkbox"/> Lives with Parents	<input type="checkbox"/> Single Parent	<input type="checkbox"/> With Spouse & Children	<input type="checkbox"/> Common law	<input type="checkbox"/> Other	<input type="checkbox"/> No Home
Are these living arrangements shared:			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, with whom:	
Do you have a family member working at the Rising Sun?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who:	
Please provide/attach a brief assessment summary, (Assessment Summaries completed within 6 weeks of this application may be substituted and attached) including summarization of any assessment processes completed with the client (e.g. SASSI, MAST, DAST, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, school, psychological, spiritual, emotional).						

<b>Client's Stage of Readiness:</b>
<input type="checkbox"/> Pre-contemplation - Not considering change; resistant to change <input type="checkbox"/> Contemplation - Unsure of whether or not to change; chronic indecision <input type="checkbox"/> Determination - Preparation; committed to changing behavior within one month <input type="checkbox"/> Action - Begin changing behavior <input type="checkbox"/> Maintenance - Behavior change has persisted for 6 months or more
Please list any questions or concerns the client has indicated during the intake process:
What other areas might need to be addressed in treatment? (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:

**REFERRAL CHECKLIST**

**Please initial which applicable items have been completed. Check off any items attached to this application:**

Item	Attached	Initials
Psychiatric evaluations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Probation order	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Current ORT Medical Assessment Forum	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assessment Summary <b>(DUSI-R) See attached</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Profile	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**PLEASE INITIAL EACH ITEM THAT HAS BEEN COMPLETED:**

Item	Initials
Confirmation of transportation to/from the treatment center	
Confirmation of transportation back home after completion of treatment	
All medical, dental and optical appointments have been dealt with prior to treatment	
All financial matters have been dealt with prior to treatment	
All legal matters have been dealt with prior to treatment	
Referral Signature	Date (D/M/Y)

**PLEASE NOTE:** During their stay at the Rising Sun Treatment Program  
The Thunderbird Assessment tool will be utilized for pre & post treatment evaluation.

Date of Completion DD \_\_\_\_\_ MM \_\_\_\_\_ YYYY \_\_\_\_\_

Please notify the potential Client that there will be absolutely no weekend passes during this particular program.

**THIS PERTAINS TO THE SUBOXONE AND METHADONE CYCLES ONLY.**