INPATIENT & RELAPSE PREVENTION

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

GENERAL INFORMATION			
Surname:	First Name:	Middle Name:	Nickname/AKA:
Date of Birth:	Age:	Sex:	Provincial Heath 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:	
Education:	Literacy Level:	Employment Status:	

FAMILY / RELATIONSHIPS			
Marital Status:			
Does Client have dependent children?	☐Yes	☐No	☐Not Applicable
If yes, do they have access to adequate childcare while in treatment?	☐Yes	☐No	☐Not Applicable
Are the children in care?	☐Yes	☐No	☐Not Applicable
Does the client have other dependents?	☐Yes	☐No	☐Not Applicable

Provide information on client's children or other dependents:

Name	Age	Relationship

Father's Name:	Deceased?	❑ Yes ❑ No	Community:
Mother's Name	Deceased?	❑ Yes ❑ No	Community:
Family Supports:			
Family Strengths:			

LEGAL STATUS			
Has client been court ordered to attend treatment?	☐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		
If yes, provide details:			

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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:

WITHDRAWAL SYMPTOMS		
Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?		
Symptoms		**Describe**
Blackouts	☐Yes ☐No ☐Not Applicable ☐Unknown	
Hallucinations	☐Yes ☐No ☐Not Applicable ☐Unknown	
Nausea/Vomiting	☐Yes ☐No ☐Not Applicable ☐Unknown	
Seizures	☐Yes ☐No ☐Not Applicable ☐Unknown	

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Shakes	☐Yes ☐No ☐Not Applicable ☐Unknown	
Delirium Tremens (DT's)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Ever experienced DTs?	☐Yes ☐No ☐Not Applicable ☐Unknown	

PROCESS/BEHAVIORAL ADDICTIONS		
HAS CLIENT EXPERIENCED PROBLEMS WITH ANY OF THE FOLLOWING?		
Process/Behavioral Addiction		**Describe**
Gambling (slots, cards, Keno, bingo, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Sex (promiscuity, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Internet/texting	☐Yes ☐No ☐Not Applicable ☐Unknown	
Gaming	☐Yes ☐No ☐Not Applicable ☐Unknown	

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Social Media	☐Yes ☐No ☐Not Applicable ☐Unknown	
Other	☐Yes ☐No ☐Not Applicable ☐Unknown	

MENTAL HEALTH ISSUES		
Provide the following information about the client's health status:		
Mental Illness		**Describe**
Been diagnosed with a mental illness	☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently being treated	☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently on psychiatric medication	☐Yes ☐No ☐Not Applicable ☐Unknown	
Taking medication consistently	☐Yes ☐No ☐Not Applicable ☐Unknown	
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

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Name of psychiatrist/psychologist (if applicable):	

E. OTHER ISSUES/NEEDS	
Does client have cultural and/or spiritual beliefs and practices we need to be aware of?	☐Yes ☐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:	☐Yes ☐No
If yes, please describe:	
Are there any other significant issues we need to be aware of? If yes, please describe:	☐Yes ☐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?	☐Yes ☐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).	☐Yes ☐No
Personal Strengths:	

F. APPLICATION CHECKLIST	
Confirmation of transportation to Treatment Centre through referral	☐Yes ☐No
Confirmation of transportation back home	☐Yes ☐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.	☐Yes ☐No
Client Authorization	
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.	
Client Signature	**Date**
Referral Signature & Contact Information	**Date**

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REFERRAL INFORMATION						
Has the client completed four pre-treatment appointments?					☐Yes ☐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?					☐Yes ☐No	
What other supports would be available to your client in their community upon completion of treatment?						
Name/Resource	**Description of Support**					
PRESENT LIVING SITUATIONS:						
☐ Lives Alone, own place	☐ Lives with Parents	☐ Single Parent	☐ With Spouse & Children	☐ Common law	☐ Other	☐ No Home
Are these living arrangements shared:	☐ Yes	☐ No	If yes, with whom:			
Do you have a family member working at the Rising Sun?	☐ Yes	☐ 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).						

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 intake process:

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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	☐Yes ☐No	
Probation order	☐Yes ☐No	
Current Medical Assessment Forum	☐Yes ☐No	
Assessment Summary **(DUSI-R) See attached**	☐Yes ☐No	
Substance Abuse Profile	☐Yes ☐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 (DD/MM/YY)

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 ________

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