ALBERTA REGION

YSAC YOUTH RESIDENTIAL TREATMENT – ADMISSION FORM

Select your preference to one of the following Treatment Centres:

☐ Siksika Medicine Lodge
Siksika Nation, AB
Phone: 403.734.3444
Fax: 403.734.4433
www.siksikamedicinelodge.com

☐ Blood Tribe Youth Wellness Center
Standoff, AB
Phone: 403.737.2900
Toll Free: 1.800.527.8627
Fax: 403.737.3299
Email: achatsis@kainaicsc.ca or ksmith@kainaicsc.ca

Treatment Centre Use Only:

Admission Date: (D/M/Y)_____/____/____ Client File Number: _____

Discharge Date: (D/M/Y)_____/____/____ Registration Date: _____

PLEASE NOTE: ALL SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL BY THE REFERRAL AGENT.

Incomplete forms will be returned and may delay the intake process.
If any information is Not Applicable indicate as *NA*,
Unknown as *UNK*, and Unavailable as *UNA*.

PART 1 - APPLICATION

A. GENERAL INFORMATION

Surname:_____ Healthcare #:_____

First Name(s): _____ Address:_____

Other name known by: _____ City: _____

Date of Birth: (dd/mm/yyyy)_____/____/_____ Province:_____

Age: _____ Postal Code: _____

Gender: ☐ Male ☐ Female

Languages: Spoken _____ Parent(s)/Guardian(s):

Understood: _____ Name(s): _____

Preferred:_____ _____

Status: ☐ Status Indian ☐ Inuit ☐ Métis Home No: ( )_____

Band Name: _____ Work No: ( )_____

Treaty Area: _____ Cell No: ( )_____

Treaty # (10 digit): _____

B. REFERRAL INFORMATION

Agency Name: _____ Worker's Name/Title: _____ Telephone No: ( )_____ Fax No: ( ) _____

Email: _____

C. INTER-AGENCY INVOLVEMENT

Child & Family Services

Please check off box, if any of the following apply to the client: ☐ Temporary Guardianship Order ☐ Permanent Guardianship Order ☐ Apprehension Order ☐ Supervision Order ☐ Secure Services Order ☐ Temporary Crown Ward ☐ Permanent Crown Ward

If any were checked off, please provide the following information: (*if different from referral agent)*

Agency Name: _____

Worker's Name/Title: _____

Telephone No: ( )_____ Fax No: ( )_____

Email: _____

Youth Justice System

Has the client ever been in trouble with the law? ☐ Yes ☐ No

If yes, please explain: _____ Is the client on Probation, Temporary Absence, or a Court Order to attend treatment? Yes ☐ No ☐ If yes, please provide order: From _____ to _____

Conditions: _____

(*Upon acceptance, a copy of the probation or court order will need to be submitted*)

Is the client currently residing at a Young Offenders Centre? ☐ Yes ☐ No

Was client assigned a Probation Officer? ☐ Yes ☐ No

If yes, provide the following information: (*if different from referral agent)*

Agency Name: _____

Probation Officer Name:_____

Telephone No: ( )_____ Fax No: ( )_____

Email: _____

D. FAMILY HISTORY

Biological Mother's Name: _____

Biological Father's Name: _____

Please list all those who are **considered siblings** by the client, including biological, step, and foster siblings. If additional space is required, please list on back of page.

Name	Age	Sex (M/F)	Relationship	Lives With

Does the client live with: (please check those that apply)

☐ Mom ☐ Dad ☐ Alone ☐ Extended Family ☐ Foster Home ☐ Group Home ☐ Friends

Please indicate others persons living the home, **not including the siblings**. If additional space is required, please list on back of page.

Other persons currently living in the home			
Name	**Age**	**Sex (M/F)**	**Relationship**

Client's Belief System: ☐ Native Spirituality ☐ Catholic ☐ Protestant ☐ Anglican ☐ None

☐ Other: _____

E. EDUCATION

Is the client currently registered in school? ☐ Yes ☐ No

Is client currently attending school? ☐ Yes ☐ No

If you answered 'no' to one of the above 2 questions, please explain: _____

_____

Does the client like school? ☐ Yes ☐ No

Last school attended: _____ Highest grade completed: _____

Last year attended: _____ Telephone: ( )_____Fax: ( )_____

Did client ever attend school while high on drugs, alcohol, and/or solvents? ☐ Yes ☐ No

Is truancy a problem for the client? ☐ Yes ☐ No

Does the client have any special needs, learning disabilities, or behavioural problems that we need to be aware of? ☐ Yes ☐ No If yes, please explain: _____

_____

Did the educational institute that the client attended ever prepare an Individual Education Plan (IEP) for the client? ☐ Yes ☐ No (*If yes, please attach a copy of the IEP to this application*)

F. RELATIONSHIPS

What kind of relationship does the client have with any of the following:

Parent(s) _____

Sibling(s) if any _____

Extended family member(s) _____

Is the client satisfied with his/her family relationships? ☐ Yes ☐ No

Please explain _____

Name of person the client feels closest to and why? Provide details _____

_____

Does the client make friends easily? ☐ Yes ☐ No

Has the client ever been involved with any of the following groups? (*Mark an 'X' in all that apply*)

☐ Church ☐ Social club ☐ Sports ☐ Traditional practices ☐ Gangs

Does the client feel that he/she 'fits' in well with any of the above groups? ☐ Yes ☐ No

If yes, please explain: _____

Has the client ever sought advice from an elder(s)? ☐ Yes ☐ No

Does the client currently have a girlfriend/boyfriend? ☐ Yes ☐ No

Is the client sexually active? ☐ Yes ☐ No

G. MEDICAL HISTORY *(Please note: the medical consent form must be attached to admission form.)*

Does the client have a Family Physician? ☐ Yes ☐ No

If yes, provide name & telephone number? _____

Please provide the dates of the client's last appointment for each of the following:

Medical: _____

Dental: _____

Optical: _____

Please ensure the Medical Assessment (PART 2) is completed by a physician and attached to this application form.

H. CHEMICAL USE HISTORY

At what age did the client start sniffing solvents? _____ ☐ Not Applicable

At what age did the client start drinking alcohol? _____ ☐ Not Applicable

At what age did the client start taking other drugs? _____ ☐ Not Applicable

Please indicate if the client has ever 'abused' any of the following substances:

Substance (*circle all that apply*)	**Yes**	**No**	**Last Use** (i.e. # hours, days, weeks, months)	**Amount Per Use**
Solvents/Inhalants – glues, paint thinner, gasoline, aerosol sprays, nail polish remover, or other:				
Alcohol – beer, liquor, cough syrup, mouthwash, aftershave, or other:				
Cannabis – Marijuana, hash, hash oil				
Hallucinogens – Ecstasy, Magic, LSD, Mushrooms, peyote, or other:				
Stimulants – Crystal Meth, Crystal, JIB, Sister, GIB, or Ice, Speed, or other:				
Cocaine – crack, crack cocaine, angie, blow, coke, rock, snow, stardust, or other:				
Opiates – Oxycontin, Morphine, Percocet, Tylenol 3, T4, or other:				
Depressants –Xanax, Ativan, Librium, Serax, Heroin, Methadone, or other:				
Stimulants – Dexedrine, Adderall, Ritalin or other:				
Tobacco – Cigarette, or Chewing Tobacco				
Other:				

Does anyone else in the client's family use solvents/substances? ☐ Yes ☐ No

If yes, provide name(s) of family member(s) & solvents/substances used? _____

_____

Who does the client usually use solvents/substances with? ☐ Alone ☐ With others

Where does the client tend to use solvents/substances? Please indicate yes or no for each.

Location	**Yes**	**No**	**Location**	**Yes**	**No**
At home			Abandoned Vehicle		
A Friend's House			At a Party		
School			Outdoors		
Abandoned Building			Other:		

Has the client ever lost friends due to solvent/substance use? ☐ Yes ☐ No

Has the client ever gotten into any physical fights while using? ☐ Yes ☐ No

Has the client ever caused serious injury to self or others while using? ☐ Yes ☐ No

If yes, please explain: _____

Does the client have any medical, physical, psychological, or emotional problems due to the use of solvents/substances? ☐ Yes ☐ No

If yes, please explain: _____

Does the client feel that he/she has control over their use of solvents/substances? Yes ☐ No Has the client ever considered reducing or quitting the use of solvents/substances? Yes ☐ No Has the client been in previous treatment for their use of solvents/substance use? Yes ☐ No ☐

If yes, when & what was the reason for discharge: _____

_____

What would the client like to focus on while in treatment? _____

_____

Please identify some the client's strengths, or things he/she does well _____

_____

I. PSYCHOLOGICAL FUNCTIONING

Has the client ever spoken or wrote about killing him/herself? Yes ☐ No ☐

Has the client ever attempted to kill him/herself? ☐ Yes ☐ No

If yes, how many times & how long ago? _____ how did he/she attempt to kill him/herself? _____

Does the client frequently wander off alone when he/she is depressed (unhappy)? ☐ Yes ☐ No

Is the client currently sad or unhappy? ☐ Yes ☐ No

If yes, how often? ☐ Some of the time ☐ Most of the time ☐ All of the time

Is there any known history of sexual abuse? ☐ Yes ☐ No

Is there any known history of physical abuse? ☐ Yes ☐ No

Is there any known history of emotional abuse? ☐ Yes ☐ No

If you answered yes to any of the 3 above questions, provide details: (i.e., at what age, has it been reported, and what was the outcome or current status? _____

_____

Is there any history of family violence that this client may have been witness to? ☐ Yes ☐ No

If yes, please explain: _____

Have there been any significant losses in the client's life? ☐ Yes ☐ No

If yes, who did the client lose? _____

has the client ever received assistance to deal with the loss(es)? ☐ Yes ☐ No

please explain: _____

_____

Does the client have a bed-wetting problem? ☐ Yes ☐ No

Has the client ever run away from home? ☐ Yes ☐ No

Does the client have a history of fire setting? ☐ Yes ☐ No

If yes, please explain_____

Has the client ever demonstrated cruelty to animals? ☐ Yes ☐ No

If yes, please explain_____

Does the client have a history of destroying property? ☐ Yes ☐ No

If yes, please explain _____

Please indicate whether the client has been diagnosed with any of the following disorders?

	Yes	No
Fetal Alcohol Spectrum Disorder (FASD)		
Oppositional Defiant Disorder (ODD)		
Conduct Disorder (CD)		
Attention Deficit Hyperactivity Disorder (ADHD)		
Attention Deficit Disorder (ADD)		
Other:		

Has the client ever had any psychological testing or counseling conducted? ☐ Yes ☐ No

If yes, for what purpose? _____

Please attach any assessments conducted to-date (i.e., psycho-educational, SASSI, MAST, DAST, etc) on the client which support the application to treatment.

When the client is in a sober state:

Has he/she communicated with spirits that no one else can see or hear? ☐ Yes ☐ No

If yes, how often does this happen? ☐ Sometimes ☐ Often

Are these encounters positive or negative experiences for the client? Provide details: _____

_____

Are there times when people are not able to communicate with the client? ☐ Yes ☐ No

If yes, how often does this happen? ☐ Sometimes ☐ Often

please explain: _____

_____

J. OTHER RESOURCES

Are there currently any other agencies providing services to the client and/or family? ☐ Yes ☐ No

If yes, provide name of agency & services provided? _____

_____

K. FAMILY

Family activities/practices: What activities does the family do together? _____

_____

Family roles/relationships: How does the client's family interact with each other? _____

_____

Status in the community: How is the family perceived in the community? _____

_____

How does the client spend his/her leisure time? _____

Who is the other support people involved with the family? (i.e., elders, extended family, community groups, community workers, NNADAP, etc.)? _____

Is the client aware of the effects of solvents/substances use? ☐ Yes ☐ No

Is the family aware of the effects of solvents/substances use? ☐ Yes ☐ No

Does the family believe the client recognizes that he/she has a problem? ☐ Yes ☐ No

What steps does the family want to take to address the problem? _____

_____

Has anyone in the client's family ever received treatment for solvent/substance use? ☐ Yes ☐ No

Are the guardian(s) supportive of the client receiving treatment? ☐ Yes ☐ No

Are the extended family members supportive of the family seeking help and/or treatment for themselves or the client? ☐ Yes ☐ No

Would the family be willing to come to our treatment centre to observe the program in action as part of the intake process? ☐ Yes ☐ No

L. WORKER'S RECOMMENDATIONS

Upon completion of the treatment program, what other supports are available to the client in their community?

Name of Agency/Resource Person	Description of Support

What is your assessment of the client's readiness and motivation to attend residential treatment?

_____

_____

Are there any additional issues that we need to be aware of? _____

_____

_____

PART 2 – MEDICAL ASSESSMENT

All clients must have this form completed in full by a licensed physician prior to treatment.

Please note: **First Nations & Inuit Health – Alberta Region – Non-Insured Health Benefits** covers a maximum of $60.25 for a medical assessment by physicians in Alberta.

Please mail or deliver invoices only directly to: (Do not fax)

Regional NNADAP Treatment Referral Client Coordinator,
Suite 730, 9700 Jasper Avenue,
Edmonton, AB, T5J 4C3

Applicant's Name: _____

Treaty # (10 digit):_____Alberta Health Care #: _____

A. MEDICAL HISTORY (Please explain any 'yes' responses in Section B)

CONDITION	DIAGNOSED	
	YES	NO
Central Nervous System Disorder		
Chronic Bronchitis		
Asthma		
Heart Problems – Current Blood Pressure: _____		
Gastrointestinal Problems		
Pancreatic Problems		
Kidney or Urinary Problems		
Diabetes/hypoglycemia		
Epilepsy		
Tuberculosis		
Chronic Pain		
Eating Disorder		
Sleep Disorder		
Withdrawal Symptoms – Seizures, other		
Mood Disorder – Major Depressive Disorder, other		
Psychotic Disorder – Schizophrenia, etc.		
Personality Disorder		
Liver Problems – Hepatitis B or C		
HIV/AIDS		
Sexually Transmitted Disease		
Medical Confirmation of Pregnancy – If applicable, # of weeks _____		
Allergies (i.e., drug, food, other)		
Other: _____		

B. If 'Yes' was indicated for any conditions in Section A, please explain: _____

_____

C. CURRENT MEDICATIONS (if applicable)

Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. Please note: mood altering medications must be prescribed and monitored by a psychiatrist for management of a mental illness.

MEDICATION	DOSE	FREQ	START DATE	END DATE	INDICATION

Reminder to Physician: For the client's safety and well-being while in residential treatment, please ensure that he/she brings enough of their medications (*in the original packaging from the doctor or pharmacist*) for their time in treatment (4 months).

In your opinion, is this client medically stable and appropriate for admission to Residential Addiction Treatment? ☐ Yes ☐ No

In the past 6 months, has the client been using the medication appropriately? ☐ Yes ☐ No ☐ N/A

If no, please explain:_____

_____

Physician's Name (print):_____Date:_____

Address:_____ City: _____ Postal Code: _____

Phone: ( )_____Fax: ( )_____

Other: (i.e., psychiatrist or specialist relevant to this admission) _____

Phone: ( ) _____ Fax: ( ) _____

Physician's Signature:_____

Physician Stamp

Client Consent to Release Information

I hereby authorize the above named physician to release the information to the treatment centre intake coordinator, as required, to assess my suitability for acceptance and admittance to the residential treatment program.

Legal Guardian's Signature: _____ Date: _____

PART 3 – APPLICANT CHECK LIST

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

Item	Attached	Initials
Completed copy of Medical Assessment Form	☐	
Copy of legal documents – Probation/Court Order	☐	
Copy of Assessments/Evaluations	☐	
Copy of Alberta Health Care Card and Treaty card	☐	
Copy of Birth Certificate		

Please initial each item that has been completed:

Item	Initials
Confirmation of transportation to the treatment centre	
Confirmation of transportation back home after completion of treatment	
All medical, dental, and optical appointments have been dealt with prior to admission	
Informed that if anytime during the treatment process the client self-terminates, the client will assume the costs of the next trip to access medically required health service and provide a confirmation of attendance to either the Health Centre Transportation Coordinator (or Health Canada). (**New Policy**)	

If and when the client is accepted for admission to the treatment centre, the following personal items are required:

Personal Items
Ø Toiletries (toothbrush, toothpaste, shampoo, conditioner, deodorant, etc)
Ø For females – feminine products
Ø Bathing suit and shorts
Ø Warm jacket, sweater, boots, gloves, etc. (wintermonths)
Ø Sneakers and casual shoes
Ø Towels and face cloths
Ø Socks, underwear, shirts, pants, pajamas, slippers, etc.

I/We, the parent(s)/ legal guardian(s) of_____fully understand that transportation back home will only be provided if my child completes the program. In any case, I confirm I have made appropriate travel arrangements for my child's return home.

Client's Signature:_____Date: _____

PART 4 – PARENTAL PARTICIPATION FORM

The treatment centre recognizes and acknowledges the importance of engaging cooperative and willing parent(s), guardian(s), and other family in the process of family counseling children in care. One element of this process includes visits by the aforementioned parties with the client and in compliance with the centre's visitation policies and procedures.

I,_____and
Legal Guardian (print name)

I, agree to Legal Guardian (print name)

participate with my child during their stay at the
Youth Treatment Centre upon the request of the treatment team.

Legal Guardian's Signature:_____Date: _____

Legal Guardian's Signature:_____Date: _____

Witness Signature:_____Date: _____

PART 5– PARENT/GUARDIAN CONSENT TO TREATMENT

I/We, the parent(s)/ legal guardian(s) of _____do hereby agree and consent to have the above named admitted to residential treatment and are certain that the above named is willing to fully participate in the treatment program.

Parent/Guardian Name(s): (*please print*) _____

_____

Parent/Guardian Signature(s): _____

_____

Date: _____

Witness: _____

YOUTH CONSENT

If I am accepted into the Treatment Center, I understand that I will be expected to sign a "Treatment Agreement." If I choose not to sign I may be released/discharged at the earliest convenience.

I understand that by signing this form I agree to fully participate in treatment.

Client Name: (please print) _____

Client Signature: _____

Date:_____

Witness: _____

PART 5 –
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:_____ Date of Birth: _____

I,_____parent/guardian of_____,
do hereby consent and authorize the release of records indicated below: (Please check off)

- ☐ Birth Certificate
- ☐ Medical Records
- ☐ School Records
- ☐ Assessments
- ☐ Other Assessments: Specify: _____

I also understand that this authorization will remain on file and serve as an ongoing authorization while my child is a client of the treatment centre.

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of Witness Date