**Application for Admission**

**Application Requirements:**

1. Application form completed and signed by client
2. Application medical completed by referring physician or nurse practitioner.

**Admission Criteria**:

In addition to clients being motivated, their ability to stop using substances and having adequate family support, the following criteria apply to individuals being accepted to the SN-ATC:

**Individuals May Be:**

▪ Self-referred

▪ Referred by a healthcare professional

▪ Admitted with physical limitations

▪ On Opioid Replacement Therapy (ORT) and/or psychiatric medications at time of admission

**Individuals Must:**

▪ Remain alcohol and drug free for a minimum of 6 days prior to admission

▪ Be willing and able to actively engage in the 90-day Treatment Center Program

▪ Be medically and psychiatric stable; must be cleared by a physician or nurse practitioner prior to admission (accepting women less then 5 months pregnant). Must be able to self manage medication(s).

* All legal, medical, education, employment, and childcare services must be dealt with prior to admission so that it will not interfere with your treatment program.

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| **Legal First Name:** | **Legal Last Name:**  | **Middle Name:**  |
| **Date of birth:**  | **Health Care #:** | **Age:** |
| **Gender: F/M/Non-binary/Prefer not to disclose (X)** |
| **Contact #:**  | **Contact #2:**  |
| **Marital Status: Single Married Common-Law**  **Separated Divorced**  |
| **Mailing Address:**  |
| **City:** | **Province:** | **Postal Code:** |
| **Emergency Contact Name:** | **Relation:** | **Emergency Phone:** |
| **Treaty Status (if applicable)**  |
| **Treaty:**  | **Metis:**  |
| **Band Name:**  | **Treaty No:** |
| **Residence: On Reserve**  | **Off Reserve**  |
| **Next Kin (in case of emergency):**  | **Relationship:**  |
| **Primary Number:** | **Secondary Number:**  |
| **Second Next of Kin:** | **Relationship:** |
| **Primary Number:** | **Secondary Number:**  |
| **Patient name:** | **Signature:** | **Date:** |

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| **Legal Status:**  |
| Has client been court ordered to attend treatment? **Yes or No** | Probation Order/Parole Conditions attached? **Yes or No** |
| Is client currently incarcerated? **Yes or No. If yes, please explain:** |
| Is the client under any of the following legal conditions? **(Please circle all that apply; Bail, Parole, Probation, Temporary Absence Order or Other. Provide details, dates, etc.)** |
| Is the client currently facing any other charges? **Yes or No; If yes, please explain.** |
| **Patient name:** | **Signature:** | **Date:** |

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| **Please describe in detail your addiction(s):** |
| **What substance(s) do you use commonly/current? What primary substance(s) do you use often?**  |
| **Pattern of use of primary substance(s)? (e.g., daily, binge)** |
| **How long have you used primary substances for?** |
| **When did you last use?** |
| **What other substance(s) have you used in the past?** |
| **Pattern of use?** |
| **How long did you use substance(s) for?** |
| **Patient name:** | **Signature:** | **Date:** |
| **When did you last use (other) substance(s)?** |
| **Smoker: Y or N** |  **Do you vape: Y or N** |
| **Other addiction concerns?** |
| **Are you currently experiencing any withdrawal symptoms?**  |
| **Patient name:** | **Signature:** | **Date:** |

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| **Treatment History:** |
| **Have you previously attended treatment for addictions and if so, when?** |
| **Reason for previous treatment?** |
| **If so, how long have you been alcohol or drug free?** |
| **What are your reasons for wanting to attend treatment this time?** |
| **Please describe in detail how this has affected your daily life: (e.g., family, relationships, employment, health)** |
| **What other concerns would you like to address in treatment?** |
| **Do you require additional support? (Reading, writing, English, wheelchair accessibility, hearing / eyesight difficulties, dietary restrictions etc.). If yes, please describe in detail?** |
| **Patient Name:** | **Signature:** | **Date:** |

**\* Medical assessment must be completed by a medical doctor or nurse practitioner.**

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| **Patient name:** | **Date of Birth:** | **Health Care Number:** |
| **Medical Details:** |
| **Do you have allergies? (Medication, food, environment) Y or N** |
| **Medications: Please attach a copy if needed** |
| **Medication:**  | **Dose** | **Route** | **Frequency** | **Reason** **given** | **Start / End****date** |
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| **Describe current medical condition, if any:**  |
| **Do you have or have you experienced mental health concerns, if yes, explain: (e.g., panic attacks, hallucinations, rage, mood swings, etc.)** |
| **Please describe how your mental health / substance use has affected you and your relationships:**  |
| **Physician Name:** | **Signature:** | **Date:** |
| **Are you currently seeing a doctor? Psychologist, psychiatrist (including medication prescription)? If yes, please provide detail:** |
| **Are there any concerns of the following?** (current severity of mental health concerns) | **No** | **Yes** | **Comments:**  |
| Mental development or learning disorder? (e.g. depression, anxiety, bipolar, ADHD, phobias, psychosis, schizophrenia) |  |  |  |
| Acute medical conditions ? |  |  |  |
| Physical disorders aggravating mental health? |  |  |  |
| Related psychosocial and environmental factors? |  |  |  |
| **Psychological Approval:**  |
| **Physician Name:** | **Signature:** | **Date:** |

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| **Patient Name:**  | **Date of Birth:**  | **Health Care Number:**  |
| *Please send relevant reports, e.g., CBC, Hepatic profile, electrolytes, urinalysis, etc.*  |
| EENT |
| Respiratory (asthma, COPD) | Cardiovascular  |
| Gastrointestinal | Genitourinary (e.g., incontinence, BPH, STD) |
| Musculoskeletal (chronic pain, RA, OA, gout) | Integumentary |
| Neurological: History of seizures: Yes or No |
| Hematological/Immune | Evidence of withdrawal or intoxication? |
| **Physical examination:** |
| Height | Weight | Temperature | Pupils | Heart Rate | Blood Pressure | Respiration rate |
| Skin | Diaphoresis | Tremor |
| Is the patient diabetic?Yes or No | Year Diagnosed? | Is the patient stable?Yes or No |
| Does the patient have MRSA and wound?Yes or No? Specify latest swabs? |
| Is there cognitive impairment?  |
| Needs assistance ambulating?Yes or No |
| When was the patient’s last PAP smear? | Results? |
| Is the patient pregnant?Yes or No | LMP:  |
| Physician managing pregnancy?  | Location of delivery? |
| **Physician Name:** | **Signature:** | **Date:**  |

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| **TB Screening and History:** |
| **Check appropriate boxes:**  | **Yes** | **No** |
| Cough lasting more then 2 weeks? |  |  |
| Weight loss, if yes specify lbs and time |  |  |
| Night Sweats |  |  |
| Fever |  |  |
| Blood in sputum |  |  |
| Previous active TB and treatment  |  |  |
| Previous chest x-ray results |  |  |
| Extensive travel  |  |  |
| Other risk factors  |  |  |
| Furth TB screening / assessment required – if yes, send results  |  |  |
| **Medical Approval:**  |
| Is the patient medically stable and appropriate for admission to Stoney Nakoda Adult Treatment Centre? Yes or No |
| **Psychiatric Review / History:** * **Attach any evaluations and or discharge summaries and results)**
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| **Physician Name:** | **Signature:** | **Date:** |

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| **Have you ever had thoughts of suicide / self harm or attempted suicide? If yes, please describe.** |
| **What goals do you have for your recovery? Is there anything else we need to how on we can support you?** |

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| **Physician Name:** | **Signature:** | **Date:** |

**This section is to be filled out by the referring person (Self-refer, skip this step):**

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| **Name of referring person:**  | **Relationship:** | **Contact No.**  |
| **Agency:** | **Business Address:** |
| **Contact No.**  | **Fax No.**  |
| **Payment Method:** **Alberta resident Status/Indigenous AISH** |

**The following medications are restricted at Stoney Nakoda Treatment Centre:**

\*\*Note: This list is not exhaustive and other medications may be subject to restriction. If you are stabilized on a medication or a stimulant, then this will be assessed case by case.

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| **Opioid Pain Medications**• Codeine & Codeine containing products (e.g. Tylenol #3)• Morphine (eg. Kadian)• Fentanyl• Hydromorphone (Dilaudid)• Oxycodone (Percocet, OxyNeo)• Meperidine (Demerol)• Tapentadol (Nucynta)• Tramadol (Zytram, Ralivia, Tridural)• Pentazocine (Talwin)• Propoxyphene (Darvon) | **Benzodiazepines**• Alprazolam (Xanax)• Bromazepam (Lectopam)• Lorazepam (Ativan)• Oxazepam (Serax)• Temazepam (Restoril)• Triazolam (Halcion)• Chlordiazepoxide (Librium)• Clonazepam (Rivotril)• Clorazepate (Tranxene)• Diazepam (Valium)• Flurazepam (Dalmane)• Nitrazepam (Mogadon) |
| **Psychostimulants**•Dextroamphetamine (Dexedrine)• Amphetamine Mixed Salts (Adderall XR)• Lisdexamfetamine (Vyvanse CASE BY CASE)• Methylphenidate (Ritalin, Biphentin, Concerta)• Modafinil (Alertec) | **Miscellaneous**• Varenicline (Champix)• Nabilone (Cesamet)• Dronabinol (Marinol)• Medical Marijuana• Zopiclone (Imovane, Zolpidem) |

**What if I am taking Methadone or Suboxone for opioid dependence treatment?**

Methadone and Suboxone will be accepted at SN-ATC only if your physician has indicated you are on a stable maintenance dose. We suggest dosing prior to coming in on your admission day to avoid any delay in receiving your medication.

 **Initial:**