**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)** | | | | |
| **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:**