YOUTH TREATMENT - INTAKE FORM

Treatment Centre - Please check one:

❑ Young Spirit Winds, Hobbema ❒ Kainai Adolescent Treatment Centre, Blood Tribe
❒ Siksika Youth Wellness Centre

OFFICE USE ONLY - TREATMENT CENTRE	
Registration Date: _____	Admission Date: _____
Actual Date of Admission: _____	Cancellation Date: _____

PLEASE NOTE: All questions must be answered, otherwise form may be returned and process could be delayed

Part 1 - Referral Information:

Name:_____ Title: _____

Agency:_____

Address:_____

Telephone: _____ Fax: _____

Part 2 - Client Information:
A. General Information

Surname: _____ First Name(s):_____

Nickname or other name known by:
_____

Gender: □ M □ F Date of birth: (MM/DD/YY) _____ Age: _____

Languages: spoken _____ preferred _____ understood _____

Status Indian: □ Yes □ No First Nation / Band Name:_____

Treaty number (10-digit):_____ Health insurance number:_____

Address (Home):_____

City: _____ Prov: _____ Postal Code: _____

Tel:_____

EMERGENCY CONTACT:

Mother's Name: _____

Address: _____

Telephone: _____

Father's Name: _____

Address: _____

Telephone: _____

Legal Guardian's Name: _____

Address: _____

Telephone: _____

B. Substance Abuse Profile Date: (MM/DD/YY)_____

Substance use as of : Last use...
A: Within last 24 hours **B**: 2-7 days **C:** 8-30 days **D:** over 1 month **E**: over 1 year

1. A - alcohol (e.g. beer, whiskey, cough syrup, mouthwash, aftershave,) _____
2. AN - antidepressants, paxil, zoloft, prozac _____
3. CA - cannabis, marijuana, hashish, hash oil _____
4. CM - crystal methamphetamine _____
5. CO - cocaine, crack cocaine _____
6. H - hallucinogens, angel dust, acid, peyote, magic mushrooms, ectasy , etc _____
7. HE - heroin _____
8. N - narcotics _____
9. Prescription drugs:
   □ Opiates - Tylenol 3, T4, Morphine, Percocet, Oxycontin, etc
   □ Benzodiazepines - Ativan, Valium, Xanax, Serax, Mogadon, Librium, etc
   □ Other - Specify _____
10. S - solvents / inhalants (e.g. gasoline, aerosols, paint thinner, glue, nail polish remover, rush, white out, hair spray, antifreeze) _____
11. T - tobacco (e.g. cigarette, cigar, chewing tobacco) _____
12. O - other _____

Non-traditional tobacco: ❒ yes ❒ no ❒ sometimes ❒ 1 - 3 times daily ❒ 4+ times daily

C. Family and Home Environment:

Family type: ❒ Living Alone ❒ With Parents ❒ Extended Family ❒ Group Home ❒ Foster Home

Was the youth adopted? ❒ yes ❒ no

Has the youth ever been in foster care or removed from his/her home? ❒ yes ❒ no
If yes, please provide more information: _____

_____

Do either primary caregivers abuse drugs, alcohol or solvents? ❒ yes ❒ no

Are there other people living in the youth's home who abuse drugs, alcohol or solvents? ❒ yes ❒ no
If yes, are they related to the youth? ❒ yes ❒ no

Does the youth have positive role models in the family setting? ❒ yes ❒ no

If yes, whom? _____

Does the family indicate an interest in family therapy? ❒ yes ❒ no

If yes, please provide more information and number of family members and ages to be involved: _____

_____

_____

If applicable, number of children and ages: _____

Do your children live with you? ❒ Yes, if not all, how many? _____ ❒ no

Number of siblings and ages: _____

Number of extended family living in the home: _____

D. School and Recreation:

List of Schools attended:

1. School: _____ Grade: _____

Address: _____

Telephone: _____ Fax: _____

Student identification number: _____ Dates: _____

2. School: _____ Grade: _____

Address: _____

Telephone: _____ Fax: _____

Student identification number: _____ Dates: _____

3. School: _____ Grade: _____

Address: _____

Telephone: _____ Fax: _____

Student identification number: _____ Dates: _____

Additional Information: _____

Did the youth ever attend school while high on drugs, alcohol and/or solvents? ❒ Yes ❒ No

Is truancy a problem for the youth? ❒ Yes ❒ No

Does the youth require general monitoring of school work in order to complete the tasks? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have learning problems which require a specialized academic program? ❒ Yes ❒ No

Please specify: _____

Does the youth have a severe learning disability or behavioural problem which requires special intensive individual programming? ❒ Yes ❒ No

Please specify: _____

_____

Is the youth involved in extra-curricular school activities (i.e. sports, clubs, dancing)? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth enjoy group recreational activities (i.e. board games, sports, dances)? ❒ Yes ❒ No

Please specify: _____

_____

D) Additional information (continued):

Does the youth regularly participate in crafts or art work? ❒ Yes ❒ No

Please specify: _____

_____

Has youth been medically diagnosed with a psychiatric illness? ❒ Yes ❒ No

If yes, please specify: _____

_____

ADHD ❒ Yes ❒ No

Fetal Alcohol Spectrum Disorder (FASD) ❒ Yes ❒ no

Has a psycho-educational assessment been made? ❒ Yes ❒ No

If yes, please specify: _____

_____

If yes, is therapy required? ❒ Yes ❒ No

If yes, please specify:_____

_____

E) Supervision and Behaviour Managment:

Does the youth require more supervision, structure and routine than his/her peers? ❒ Yes ❒ No

Please specify: _____

_____

Do any of the youth's siblings have any behavioural management issues? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth require any medication to assist in the management of his/her behaviour? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have a history of fire setting? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have a history of demonstrating cruelty to animals? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have a history of destroying property? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have any eating problems? ❒ Yes ❒ No

Please specify: _____

_____

Has the youth experienced marked changes in weight and/or eating habits? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have a history of physical aggression toward peers? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have a history of physical aggression toward authority figures and/or adults? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have sever and/or potentially dangerous antisocial or self-destructive behaviours requiring intensive therapeutic intervention? ❒ Yes ❒ No

Please specify: _____

_____

Has the youth ever run away from home? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have any sleeping problems? ❒ Yes ❒ No

Please specify: _____

_____

Does the youth have a history of suicide attempts? ❒ Yes ❒ No

If yes, when was last attempt: _____

How many times? _____

Method of attempt? _____

Does the youth have a history of sexually acting out? ❒ Yes ❒ No
If yes, was child sexually abused? ❒ Yes ❒ No
Was child sexually exploited? ❒ Yes ❒ No
Did child sexually victimize another child or youth? ❒ Yes ❒ No
Has the youth ever demonstrated self-destructive behaviours? ❒ Yes ❒ No
(i.e. self-mutilation, risk taking)?
Please specify: _____

Does the youth have a bed-wetting problem? ❒ Yes ❒ No

F) Inter-Department, Inter-Agency Involvement

Has the youth been involved with the criminal justice system? ❒ Yes ❒ No

If yes, please specify: _____

_____

Is the youth currently in a Young Offenders Centre ❒ Yes ❒ No
Is the youth currently on parole? ❒ Yes ❒ No
Is the youth currently on probation or court order? ❒ Yes ❒ No
If yes, please specify conditions and provide copy of conditions: _____

_____

Has the youth been involved with any of the following professionals?
❒ Social Services ❒ Court Worker ❒ Mental Health Worker ❒ Police
❒ Therapist (psychologist, speech pathologist, psychiatrist, social worker, occupational therapist) ❒ Other

G) Losses

Has the youth lost a family member to:

❒ Suicide	❒ Parent	❒ Sibling	❒ Extended Family Member or	❒ Close Friend
Murder	❒ parent	❒ sibling	❒ extended family member or	❒ close friend
Accidents or illness	❒ parent	❒ sibling	❒ extended family member or	❒ close friend
Divorce or separation	❒ parent	❒ sibling	❒ extended family member or	❒ close friend
Incarceration	❒ parent	❒ sibling	❒ extended family member or	❒ close friend
Loss of a pet	❒ Yes ❒ No			

if yes to any, please provide details:_____

_____

H) Relationships

Please name the youth's significant relationships - positive: _____

_____

Negative: _____

Does the youth abuse substances with these? ❒ Yes ❒ No

If yes, please specify: _____

_____

What kind of relationship does the youth have with any of the following?

❒ Parent _____

❒ Sibling _____

❒ Extended family member _____

❒ Close friend _____

Has the youth been involved with any of the following?

❒ Church Groups ❒ Community Groups ❒ Social or sport clubs ❒ Aboriginal traditional practices ❒ Gangs

Additional Information: _____

_____

Does the youth feel that he/she 'fits in' well with these groups? Please specify: _____

_____

Who does the youth get along with and why? _____

_____

Does the youth make friends easily? ❒ Yes ❒ No
Is the youth satisfied with his or family relationships? ❒ Yes ❒ No

If no, please specify: _____

_____

I. Holistic View of the Client:

Please provide a brief description of the youth's spiritual background. Are there any impairments because of the substance abuse?

_____
_____
_____
_____

Please provide a brief description of the youth's thought patterns and learning capabilities. Are there any impairments because of the substance abuse?

_____
_____
_____
_____

Please provide a brief description of the youth's physical well being. Are there any impairments because of the substance abuse?

_____
_____
_____
_____

Please provide a brief description of the youth's overall emotional functioning. Are there any impairments because of the substance abuse?

_____
_____
_____
_____

Referral Signature: _____

Client Signature: _____

Parent Signature: _____

Legal Guardian Signature: _____

Date: _____

Part 3 - Medical Assessment: **All applicants must have this form completed by a physician.**

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**. The invoice has to include the client's treaty number (full ten digit) and confirmation that the invoice is a medical assessment.

Please send the invoice directly to: **Regional NNADAP Treatment Referral Client Coordinator, Suite 730, 9700 Jasper Avenue, Edmonton, AB T5J 4C3. FAXES WILL NOT BE HONOURED.**

Applicant's Name: _____

Treaty Number (10 digit): _____ Alberta Health Care Number: _____

A. Any history of.....(please explain any "yes" responses in section B

Yes	No	
❑	❑	1. Central Nervous System Disorder (i.e. memory loss, poor concentration, peripheral neuropathy)
❑	❑	2. Chronic bronchitis, asthma
❑	❑	3. Heart problems - current blood pressure _____
❑	❑	4. Gastrointestinal problems
❑	❑	5. Liver problems: Hepatitis B & C
❑	❑	6. Pancreatis
❑	❑	7. Kidney or urinary problems
❑	❑	8. Sexually Transmitted Diseases
❑	❑	9. HIV/AIDS
❑	❑	10. Diabetes
❑	❑	11. Epilepsy
❑	❑	12. Chronic pain
❑	❑	13. Allergies: _____
❑	❑	14. Eating disorders
❑	❑	15. Sleep disorders
❑	❑	16. Withdrawal symptoms, seizures, etc.
❑	❑	17. Any other medical problems:
❑	❑	18. Medical confirmation of pregnancy _____ weeks.

B. Please explain any "yes" responses: _____

_____

_____

_____

C. TB Screening: Symptoms & History

Yes	No	
❑	❑	1. Presence of cough lasting more than 2 weeks
❑	❑	2. Weight loss: _____ # of pounds _____ length of time. _____
❑	❑	3. Night sweats
❑	❑	4. Fever
❑	❑	5. Fatigue
❑	❑	6. Haemoptysis (blood sputum).

Yes	No	
❑	❑	7. Recent or past exposure to TB.
❑	❑	8. Previous active TB and treatment:
❑	❑	9. Previous significant Mantoux results or chest x-ray results.
❑	❑	10. Correctional facility residence:
❑	❑	11. Poor general health status and risk factors for progression of disease.

N.B. Confirmation from the physician and/or public health nurse that the applicant is free from active TB must be received prior to confirmation of residential admission date.

D. Are there any special problems (physical or psychological) that should be considered in the treatment of this applicant (ie. difficulty with stairs or long corridors, anxiety attacks, etc.)?

_____

_____

_____

_____

E. Current medications (including prescription medications and over-the-counter drugs)

Drug Name	Dose/Schedule	Prescribed by	Length of time used	Clinical Indication

F. Past and present mental health problems (i.e. depression, psychosis including hospitalization):

_____

_____

_____

_____

History of suicidal attempts? ❑ Yes ❑ No

Please remind the applicant:
In order to be admitted to residential treatment, **the applicant must remain alcohol and drug free for a minimum of 5 days prior** to their admission date; **14 days for patients using BZD**; and be well enough to participate in the program.

Are you the applicant's regular physician? ❑ Yes ❑ No

Physician's signature: _____

Physician's name: _____

Telephone: _____ Fax: _____

Date: _____

Address: _____

City: _____ Postal Code: _____

I hereby authorize the above named physician to release the information to the National Native Alcohol and Drug Abuse Program and its staff as required to assess my suitability for acceptance and admittance to the residential treatment program.

Applicant's Signature: _____ Date: _____

Physician's Stamp:

Part 4 - Applicant Check list:

- ❑ Letter of confirmation; indicating medical, dental, optical, financial and legal matters have been dealt with.
- ❑ Confirmation of transportation to the Treatment Centre.
- ❑ Confirmation of transportation back to home after completion of the program.
- ❑ Informed that if at anytime during treatment 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 service and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada**. (New policy)**
- ❑ Items required:
  - ❑ toiletries (toothbrush, toothpaste, shampoo, deodorant, etc.)
  - ❑ bathing suits and shorts
  - ❑ appropriate clothing
  - ❑ 2 pairs of running shoes for indoor/outdoor activities
  - ❑ towels and facecloths
  - ❑ medications (if prescribed by physician, need to be handed to intake worker upon arrival)
  - ❑ provincial health care card (or photocopy of health card)
  - ❑ psych assessment if completed

I fully understand that transportation back home will only be provided if I complete the program.

In any case, I confirm I have made appropriate travel arrangements for my return home.

Signature: _____ Date: _____

Part 5 - Referral Checklist	**Initials**
FNIH pre-authorization treatment services has been received	_____
All medical, dental and optical appointments have been dealt with prior to admission	_____
All financial matters have been dealt with prior to treatment	_____
All legal matters have been dealt with prior to treatment	_____
Full up-to-date medical assessment form have been completed and forwarded to treatment centre	_____
If client paid for the medical assessment out-of-pocket, the client has been provided and understands the information for reimbursement through Non-Insured Health Benefits	_____
Confirmation of transportation to the Treatment Centre	_____
Confirmation of transportation back to home after completion of the program	_____
Client has been notified and understands the Non-Insured Health Benefits **policy change** whereby anytime during treatment 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. Arrangements have been made for transportation back home if the client does not complete the program**	_____
Relapse prevention plan has been submitted to the Treatment Centre	_____
All pertinent information has been submitted to the Treatment Centre	_____

_____ _____

Referral signature Date

YOUTH TREATMENT

PARENTAL PARTICIPATION FORM

I,_____ and

Name of parent or legal guardian

I, _____ agree to

Name of parent or legal guardian

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

Signature: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

YOUTH TREATMENT

CONSENT TO TREATMENT

I do hereby consent to admission to a Youth Treatment Centre and agree to cooperate with required physical examination and laboratory testing, prescribed medical care, psychological/psychiatric testing procedures, evaluation, treatment and recommended aftercare.

I understand that some of the medical procedures may be performed outside the Youth Treatment Centre facility and I consent to being transported to the appropriate referral agency for specified testing or treatment as may be deemed necessary.

Client Signature: _____

Parent or Guardian Signature: _____

Witness Signature:_____

Date: _____

YOUTH TREATMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____ parent or legal guardian of

_____, do hereby consent and authorize the release of the following information:

_____Birth Certificate

_____Medical Records

_____School Records

_____Assessments

_____Other assessments(specify)

In respect of:

_____ _____
(Name of child) Date

_____ _____
Signature of parent or legal guardian Date

_____ _____
Witness Date