NAME: ______________________________ D.O.B. ____________________________

Assessment & Referral Package

ʼNa̲mgis Treatment Centre

Box 290
Alert Bay, BC V0N 1A0
Phone: (250) 974-5522 Ext: 2131
Intake Fax: (250) 974-2257
www.namgis.bc.ca
MaryH@namgis.bc.ca

NAME: ______________________________ D.O.B. ___________________________

'NAMGIS TREATMENT CENTRE
Assessment & Referral Package

Admission forms must be filled completely
before admission can be accepted.
Incomplete forms will be returned.

Personal Identification

Application Date: ___ / ____ / _____
Day Month Year

Last Name (legal): ______________________ Birth Last Name (if different)__________________
(Please Print) (Please Print)

First Name(s): _________________________ Known As: (Nickname): ____________________
(Please Print) (Please Print)

Middle Name:__________________________

Personal Health Number (PHN)_________________________ S.I.N ____________________

Birth Date: ______ / ____ / ________ Gender: Male _____Female _____
Day Month Year

Address:_________________________________ ___________________________________

City: ___________________________________Province: _____ Postal Code: ____________

Telephone #: (____)____________________Cell#: (____) __________________________

Email: _________________________________

Native Status: ☐ YES ☐ NO DIA #: ______________________________

Band Name:____________________________ Band #: ______________________________

Ancestry/Nation:_________________________ Living On _____ Off _____ Reserve

Marital Status:
Single ☐ Common-law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Emergency Contact:______________________Relationship: ____________________

Address: ______________________________

Telephone #: ___________________________

Referring Counsellor Name: ____

Address: ____________________________ ____________________________________

Telephone #: _________________________ Emergency #: _____________________

Fax:_________________________________

NAME: ________________________________ D.O.B. _____________________________

Personal

1. Was the client raised on-reserve? ☐ YES ☐ NO
2. Has the client been raised by his/her natural parents? ☐ YES ☐ NO
3. Does the client state that addictions are a problem to his/her well being? ☐ YES ☐ NO
4. Does the client state that sobriety is needed in order to change? ☐ YES ☐ NO
5. Are certain areas of the client's life affected by substance abuse? ☐ YES ☐ NO
6. Has there been a death in the family due to substance abuse? ☐ YES ☐ NO
7. Number of children:_____ At Home ____In Temp Care______ In Perm. Care______
8. Any concerns about the safety of the children left at home? ________________________
9. Education: Residential____ Public ____Gr. Completed____ Problems reading ☐ YES ☐ NO
10. Is there a history of physical abuse ____or sexual abuse ____ ? ____________________
11. Any other significant events? ____

____

Personal Relationship

1. How long has client been involved in present relationship? ___________
2. Relationship strengths: ____
3. Relationship weaknesses: ____
4. Relationship Breakdowns: ____

____

Comments: ____

____

____

NAME: ______________________ D.O.B. ______________________

Dietary

Food Allergies: ☐ YES ☐ NO ______________________

Eating Disorders: ☐ YES ☐ NO ______________________

Special Diet: ☐ YES ☐ NO ______________________

Does client eat Traditional Foods? ☐ YES ☐ NO

If not, willing to try? ☐ YES ☐ NO

Comments: ____

____

Employment

Usual Occupation: ____

Current Employment Status:

Full Time ☐ Part Time ☐ Laid-off ☐ Unemployed ☐

Has your dependency on drugs or alcohol affected your employment status? ☐ YES ☐ NO

If Yes, how? ____

____

____

Comments:____

____

____

Spiritual/Cultural

Spiritual/Cultural Involvement ____

____

Is the client involved in any spiritual/cultural activities? ______________________

____

NAME: ______________________________ D.O.B. ___________________________

Legal

Is this information relevant to this client? ☐ YES ☐ NO

If Yes: Probation ☐ Parole ☐ Federal ☐ Provincial ☐

Date of Release: ____/_____/______ Length of Supervision: ___________________
Day Month Year

Offense: ____

Alcohol or Drug related: ☐ YES ☐ NO

Eligible for weekend passes without P.O. approval: ☐ YES ☐ NO

Personal Development courses taken in institution: __________________________________

____

Any previous convictions: ☐ YES ☐ NO If yes, for what ______________________

Any charges pending? ☐ YES ☐ NO If yes, what charge ______________________

License suspension ☐ YES ☐ No If yes, how many ______

Impaired conviction ☐ YES ☐ No If yes , how many ______

Post-Treatment A/D Counsellor and Agency: ______________________________________

Address: ____________________ City: _____________________ Postal Code: _________

Parole-Probation Officer: ____________________________ P.O.Telephone: ______________

Address:_______________________________________ P.O. Fax: ___________________

City: _____________________ Postal Code:___________ P.O. Email:__________________

Weekend/Evening Contact: _________________________ Telephone:__________________

Comments: ____

____

NAME: ______________________ D.O.B. ______________________

Social/ Support

1. Client's support network: ______________________
2. Where does client seek support? ______________________
3. What supports are available to client on discharge? ______________________

____

Comments: ______________________

____

Referral Information

Referring Officer: ______________________ Referral Date: ______________________

Agency: ______________________

Address: ______________________ ______________________

Telephone #: ______________________ Emergency #: ______________________

Fax: ______________________ Email: ______________________

Comments: ______________________

____

____

History of Substance Abuse- Drugs Abused

TYPE **NOTE: Put a circle around primary drug(s) of choice.	None	Rarely	Monthly	Weekly	Daily	Age of First Use
Alcohol (beer, wine, hard liquor)						
Marijuana, Hashish						
Inhalants (glue, paint), Sprays - solvents						
Cocaine (e.g. crack, coke)						
Stimulants/Amphetamines						
Opiates-Morphine, Heroin, Dilaudid						
Tranquilizers-Ativan, Valium, Librium, Zanax						
Hallucinogen – LSD, PCP, dust						
Painkillers – Codeine, Percodan, Lalwin						
Tobacco – Other						

NAME: ________________________________ D.O.B. ________________________________

Abuse History

1. Have you ever had: DTs, Blackouts, seizures, hallucinations? ☐ YES ☐ NO

   Describe: ________________________________

2. Needle use? ☐ YES ☐ NO
3. Shared needles? ☐ YES ☐ NO
4. Practice safe sex? ☐ YES ☐ NO
5. Withdrawal symptoms after stopping? ________________________________

____

6. Have you attended residential substance abuse treatment before? ☐ YES ☐ NO

If so, where? ________________ When? ________________

Alcoholics Anonymous? A) Involvement ☐ YES ☐ NO

B) Sponsor ☐ YES ☐ NO

C) Amount of contact ________________

1. Have you received psychiatric services previously? ☐ YES ☐ NO

Comments:________________________________

____

Medical/Psychological

1. Significant Medical Issues?________________________________

____

2. Significant Psychological Issues? ________________________________

____

Comments: ________________________________

____

Presenting Problems

1. Presenting events: ________________________________

____

2. Is attendance: Court ordered ___ Ministry of Child & Family Services________Other ________
3. If ordered, contact: Name ________________________________

   Organization: ________________________________

   Address: ________________________________

   Phone: ________________ Fax: ________________

Comments: ________________________________

NAME: ________________________________ D.O.B. ______________________________

___

Client's Perspectives

1. What are the client's perceptions of his/her addiction? ______________________________

___

2. Client's wants/expectations? ______________________________

___

___

3. Other concerns: ______________________________

___

Comments:______________________________

___

Counsellor Perspectives

1. Client's emotional state: ______________________________

___

___

2. Client's insight: ______________________________

___

___

3. Level of client's motivation: ______________________________

___

___

4. Does client have a discharge plan? ☐ YES ☐ NO

Comments: ______________________________

___

Please Return the Completed Package, including the following sections, to:	Pat Davis, Program Coordinator 'Namgis Treatment Centre Box 290 Alert Bay, BC V0N 1A0 Phone: (250) 974-5522 Fax: (250) 974-2257

ADMISSION CRITERIA

1. Client recognizes that Alcohol/Drug Abuse is a problem in his/her life.

2. He/She recognizes that his/her life conflicts (impaired driving, child apprehension, etc.) are caused by Alcohol/Drug Abuse.

3. Client expresses a need and desire to change his/her lifestyle.

4. Client must be drug/alcohol free for : **10 days prior to entering treatment**.

5. Client has no outside commitment/appointments (i.e. Court Appearance, Doctor, Dentist, etc.), that would interfere with treatment.

6. Nineteen (19) years or older.

7. Couples may be referred together.

8. One (1) month prior to Treatment, the client needs to prepare him/herself for treatment by regularly attending AA or NA meeting, Support Groups, One on One counseling or workshops.

9. If incarcerated, the applicant to treatment must have completed the sentence thirty **(30)** days prior to entering the Treatment Centre.

10. Certain medical conditions may affect a client's admission.

Clients Must Have Up-to-Date TB Screen Test
<u>Within 3 Month Prior to Intake</u>

Copy of 939 TB Screening Must be included

‘Namgis Treatment Centre
Consent for Treatment

I, ___________________________, agree to enter the ‘Namgis Treatment Centre for the purpose of treating my alcohol/drug dependency problems.

I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.

I also agree to be involved in Alcohol/Drug Outpatient Counseling after attending the ‘Namgis Treatment Centre.

I understand the explanation of the above points of the “Namgis Treatment Centre Program, I therefore consent to undergo treatment at the Namgis Treatment Centre.

Comments:

____

____

____

Consent for the Release of Confidential Information

I hereby give my permission for staff of the ‘Namgis Treatment Centre to contact:

____

for information to be released which shall be limited to:
(i.e. progress during treatment, progress reports)

____

CLIENTS SIGNATURE: _______________________________DATE: ___________________

REFFERAL WORKERS SIGNATURE: ____

PRINTED NAME OF WITNESS/REFERRAL WORKER: _____________________________

REFFERAL AGENCY: __________________________ TELEPHONE: __________________

ADDRESS: ____________________________________POSTAL CODE: ________________

ALTERNATE CONTACT PERSON: ____

(If possible, for confirmation or admission processing only – not to be included in the release of confidential information prior to, during, or after treatment.)

‘Namgis Treatment Centre
Revised February 2008

Namgis Treatment Centre

MEDICAL – ADMISSION CRITERIA

1. Pre-admission medical is completed and signed by a physician prior to entry.

2. Client must be alcohol and drug free for a minimum of 10 days prior to entry. This includes: barbiturates, tranquilizers, pain killers (unless contra-indicated and prior to approval is received from the Treatment Centre Program Coordinator).

3. Client is mentally, and physically able to participate in an intense counseling experience.

4. Client does not require hospital care.

5. All diseases are under control, managed or in remission.

6. Must be free from, or under treatment for any communicable diseases or illnesses.

7. Clients must have an active Personal Health Care Number.

8. Complete a T.B. test prior to entry.

9. Vaccinations must be up-to-date.

'NAMGIS TREATMENT CENTRE

TREATMENT PRE-ADMISSION MEDICAL EVALUATION

Date: ___________________________

Client's Name: _____________________________ Date of Birth: ________ ________ _______
Please Print Day Month Year

Personal Health Number: ______________________________

A & D Counselor's Name: _____________________________
Please Print

Referral Agency: ___________________________________

Phone: (______)_________________________ Fax: (______)________________________________

CLIENT RELEASE OF MEDICAL INFORMATION

I, _______________________________, hereby request and permit my physician, to release medical facts and assessments about me to 'Namgis Treatment Centre and the above named A & D Counselor. The photo-copy fax of my signature on this form is as valid as the original.

CLIENT'S SIGNATURE: ____

DATE: ____

TO THE PHYSICIAN:

The above client is to be medically assessed as a potential participant in our six (6) week residential life skills program. Our program is designed to help people who acknowledge their drinking or drug use has interfered with their effective functioning and who are physically and mentally ready to participate in a program of intense counseling activity. As a counseling program and not a psychotherapy program the 'Namgis Treatment Centre requires a client to have a complete physical examination prior to admission.

Please mail or fax to:

Patrick Davis, Program Coordinator
'Namgis Treatment Centre
Box 290
Alert Bay, B.C.
V0N 1A0
Fax (250) 974-2257

‘Namgis Treatment Centre
Pre-Admission Medical Examination

Please mail or fax to:

Patrick Davis, Program Coordinator
Box 290
Alert Bay, B.C. V0N 1A0 Fax: (250) 974-2257

Date: ________________________________

Name: _________________________________ (Please Print)

Date of Birth: ________ ________ ________ (Day / Month / Year)

1. A) Date of last alcohol use: __________ __________ __________ (Day / Month / Year)

   B) Smoker Yes ______ No______ Date Quit _____ _____ _____ (Day / Month / Year) Current ______ per day

2. Date of last psychoactive drug use: (Please Print) ________ ________ ________ (Day / Month / Year) ____________________________ Name of Drug

   ________ ________ ________ (Day / Month / Year) ____________________________ Name of Drug

3. Current Medications:
   (dosage and frequency)

____ _______________________________________

____ _______________________________________

4. Previous or current psychiatric condition: ____

5. A) Current medical condition (s) list: ____

____

   B) Any previous/current conditions? ____

____

6. Medical problems to be followed while in treatment (M.D. is available for follow up). Please give details:

____

____

7. Is patient Pregnant? Yes ______ No _______ Not applicable _______

If yes, give details (include copy of pre-natal records: ____

____

8. TB Screen: PPD Date __________ Positive __________ Negative __________

(only if PPD is positive) CXR Date _________ Results ____________________________

Past/Current History:

9. Is there any disorder of the following?	Please Circle	
a. Hair, skin, nails (especially current or recent infestations or infections	YES	NO
b. Ear, nose, throat	YES	NO
c. Musculo skeletal system	YES	NO
d. Blood, lymphatic system	YES	NO
e. Cardio vascular system	YES	NO
f. Respiratory system	YES	NO
g. G.I. system	YES	NO
h. G.U. system	YES	NO
i. CNS – especially hx of seizures	YES	NO
j. Past history of TB	YES	NO

If yes to any of the above please give details: ____

____

10. Family History:	Alcohol/Drug Problem	YES _____	NO _____
	Psychiatric History	YES _____	NO _____
	Adopted	YES _____	NO _____

11. Physical Examination: Ht. __________ Wt.__________ B.P. __________ P. __________

	Normal	Abnormal
a. Apperance	_______	_______
b. E.N.T.	_______	_______
c. Hair, skin, nails	_______	_______
d. Reticuloendolhehial system	_______	_______
e. Musculo skeletal system	_______	_______
f. Thyroid	_______	_______
g. Cardio vascular system	_______	_______
h. Respiratory system	_______	_______
j. Central nervous system	_______	_______
k. Evidence of sexually transmitted disease	_______	_______
l T.B. test	_______	_______
m. Dental	_______	_______

12. Give details to Re: abnormal notations: ____

____

This client should not require acute medical care at time of Treatment Centre admission. Diseases are to be under control as much as possible, especially communicable diseases.

I have examined this client and find him/her to be fit to attend residential treatment.

PHYSICIAN'S SIGNATURE: ____

PRINTED NAME: ____

ADDRESS: ____

PHONE: (________)____

FAX: (________) ____

Client’s Checklist

In order for the client to be prepared for inpatient treatment, he/she should have the following when arriving at the Treatment Centre:

Please Bring These Personal Items:

- Comfort allowance (for six weeks, including change for phone calls)
- Shampoo & conditioner
- Toothbrush & toothpaste
- Comb & brush
- Deodorant
- Shaving equipment
- Loose comfortable clothing or jogging suit
- Running shoes
- Daily clothing
- Slippers
- Pajamas
- Personal sundries
- Writing paper, envelopes & stamps
- Arts & crafts
- Personal medication (physician prescribed)

The following are optional:

- Blank cassette tapes
- Family photos
- Camera
- Dress clothes for graduation dinner

IF CLIENT TRAVELS TO TREATMENT WITH PERSONAL CAR, KEYS WILL BE LEFT WITH THE CO-ORDINATOR UNTIL COMPLETION OF TREATMENT PROGRAM.

PLEASE ENSURE THAT CLIENT HAS RETURN TRAVEL FUNDS.

This may include bus tickets, plane tickets, etc. Thank you.