ALBERTA NNADAP

ADULT RESIDENTIAL TREATMENT REFERRAL FORM

- This form is to be completed by the referring NNADAP Worker or another referral agent.
- Call your preferred treatment centre to inquire about bed availability PRIOR to submitting a referral form.
- **Please refer to one treatment centre at a time**. You will be notified when the application has been approved.
- **If you have applied to more than one treatment centre for your client, please notify the other centre(s) when the application has been approved so other treatment centre beds are not being held for your client**.
- The medical assessment must be completed by a physician, nurse practitioner or registered nurse.
- **ALL SECTIONS MUST BE COMPLETED**. **INCOMPLETE APPLICATIONS WILL BE RETURNED.**

Select your preference for referral to **ONE** of the following Alberta NNADAP Adult Treatment Centres:

☐ **Beaver Lake Wah-Pow Treatment Centre**

Beaver Lake
(780) 623-2553 (Tel)
(780) 652-0571 (Edmonton Direct Line)
(403) 744-5271 (Calgary Direct Line)
(780) 623-4076 (Fax)

☐ **Kainai Healing Lodge**

Standoff
(403) 737-3757 (Tel)
(403) 737-2207 (Fax)
Website: www.kainaihealing.ca
Email: kcentre@onehealth.ca

☐ **Footprints Healing Centre**

Alexander
(780) 939-3544 (Tel)
(780) 939-3524 (Fax)
Email: footprintshealingcenter@gmail.com

☐ **Kapown Rehabilitation Centre**

Grouard
(888) 751-3921 (Toll-free)
(780) 751-3921 (Tel)
(780) 751-3831 (Fax)
Website: www.kapown.ca
Email: intake@kapown.ca

☐ **Mark Amy Treatment Centre**

Fort McMurray
(780) 334-2398 (Tel)
(780) 334-2352 (Fax)
Website: www.woodbuffalowellnesssociety.com
Email: markamy@onehealth.ca

Treatment Centre Use Only:

Registration Date: (D/M/Y) ___/___/___

Admission Date: (D/M/Y) ___/___/___

Client File Number: _________________

Cancellation Date: (D/M/Y) ___/___/___

PART 1 – CLIENT INFORMATION

Complete the following in the spaces provided. If information is not applicable indicate as NA, unknown as UNK and unavailable as UNA.

A. GENERAL INFORMATION

Surname:		First Name:	Nickname:
Date of Birth: (Y/M/D)	Age:	Gender: ☐ Male ☐ Female ☐ Transgender	Provincial Health Card #:
Address:			
Home Telephone:		Cell:	Email:
Language(s): Spoken:		Language(s) Understood:	Language(s) Preferred:
Status Indian? ☐ Yes ☐ No	Band Name:		10 Digit Treaty #:
Emergency Contact Name:		Telephone:	Relationship to client:
Employment Status: ☐ Employed full-time ☐ Employed part-time ☐ Unemployed			Mandated by employer to attend treatment? ☐ Yes ☐ No
Last grade/educational program completed:			
Does the client require assistance with reading? ☐ Yes ☐ No		Does the client require assistance with writing? ☐ Yes ☐ No	
Has the client been diagnosed with any learning problems/disabilities? ☐ Yes ☐ No If yes, please describe:			

Family Relationships

Marital Status: ☐ Single ☐ Married ☐ Common-Law ☐ Widowed ☐ Separated ☐ Divorced			
Does client have dependent children? ☐ Yes ☐ No		If yes, do they have access to adequate childcare while in treatment? ☐ Yes ☐ No ☐ Not applicable	
Are any of the children in care? ☐ Yes ☐ No ☐ Not applicable	If yes, please describe:		
Describe any current Child & Family Services involvement.			
Children Services Plan attached? ☐ Yes ☐ No ☐ Not applicable			
Does the client have other dependents? ☐ Yes ☐ No			
Please provide information on client's children or other dependents in the section below:			
Child/Dependent's Name	**Gender:**	**Age**	**Relationship to Client**
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		
Who in the family and/or community is supportive of the client?			
What does the client feel are the strengths of his/her family?			

Legal Status

Has client been court ordered to attend treatment? ☐ Yes ☐ No	Probation Order/Parole Conditions attached? ☐ Yes ☐ No
Is client currently incarcerated? ☐ Yes ☐ No if yes, please explain:	

Is the client under any of the following legal conditions? ☐ Bail ☐ Parole ☐ Probation ☐ Temporary Absence Order ☐ Other (provide details, dates, etc.)
Is the client currently facing any other charges? ☐ Yes ☐ No If yes, please explain.

Treatment History

Has client participated in a non-residential community-based substance abuse and/or mental health program? ☐ Yes ☐ No	
If yes, describe program(s):	
Is client currently prescribed: Methadone: ☐ Yes ☐ No Suboxone®: ☐ Yes ☐ No	
If yes, who is the prescribing physician?	Length of time on medication:
Other relevant information related to this medication	
Has client participated in a residential treatment program before? ☐ Yes ☐ No If yes, how many times?	
If yes, please provide information on most recent treatment experiences:	

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Describe client's reason(s) for currently requesting treatment:

B. SUBSTANCE USE ASSESSMENT

Please ask the client the following questions about alcohol use:

Question	Answer	Score
1. Do you feel you are a normal drinker? (by normal we mean you drink less than or as much as most other people)	☐ Yes ☐ No	
2. Does your wife/husband/partner/parent or other near relative every worry or complain about your drinking?	☐ Yes ☐ No	
3. Do you ever feel guilty about your drinking?	☐ Yes ☐ No	
4. Do friends or relatives think you are a normal drinker?	☐ Yes ☐ No	
5. Are you able to stop drinking when you want to?	☐ Yes ☐ No	
6. Have you ever attended a meeting of Alcoholics Anonymous?	☐ Yes ☐ No	
7. Has drinking ever created problems between you and your wife/husband/partner/parent or other near relative?	☐ Yes ☐ No	
8. Have you ever gotten into trouble at work because of your drinking?	☐ Yes ☐ No	
9. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?	☐ Yes ☐ No	
10. Have you ever gone to anyone for help about your drinking?	☐ Yes ☐ No	
11. Have you ever been in a hospital because of drinking?	☐ Yes ☐ No	

Question	Answer	Score
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	☐ Yes ☐ No	
13. Have you ever been arrested, even for a few hours, because of drunken behaviour?	☐ Yes ☐ No	

Please ask the client the following questions about drug use:

Question	Answer	Score
1. Have you used drugs other than those required for medical reasons?	☐ Yes ☐ No	
2. Have you abused prescription drugs?	☐ Yes ☐ No	
3. Do you abuse more than one drug at a time?	☐ Yes ☐ No	
4. Can you get through the week without using drugs (other than those required for medical reasons)?	☐ Yes ☐ No	
5. Are you always able to stop using drugs when you want to?	☐ Yes ☐ No	
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	☐ Yes ☐ No	
7. Do you ever feel bad about your drug abuse?	☐ Yes ☐ No	
8. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes ☐ No	
9. Has drug abuse ever created problems between you and your spouse?	☐ Yes ☐ No	
10. Have you ever lost friends because of your use of drugs?	☐ Yes ☐ No	
11. Have you ever neglected your family because of your use of drugs?	☐ Yes ☐ No	
12. Have you ever been in trouble at work because of drug abuse?	☐ Yes ☐ No	
13. Have you ever lost a job because of drug abuse?	☐ Yes ☐ No	
14. Have you gotten into fights when under the influence of drugs?	☐ Yes ☐ No	
15. Have you engaged in illegal activities to obtain drugs?	☐ Yes ☐ No	
16. Have you ever been arrested for possession of illegal drugs?	☐ Yes ☐ No	
17. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	☐ Yes ☐ No	
18. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?	☐ Yes ☐ No	
19. Have you ever gone to anyone for help for a drug problem?	☐ Yes ☐ No	
20. Have you been involved in a treatment program specifically related to drug abuse?	☐ Yes ☐ No	

C. SUBSTANCE USE PROFILE

SUBSTANCE Circle specific substance(s) or print name	**Pattern & Frequency of Use** In last 6 months: Occasional, Daily, Weekly, Monthly, Binge, Other	**Method of Use** N = nasal/ snort O = oral/ swallow IV = inject IS = inhale/ smoke	**Average Amount Used** In a 24-hour period)	**Length of Time Used** In days, months, years	**Date Last Used** Include time if known
Alcohol: E.g. beer, wine, coolers, liquor, homebrew, Lysol®, hairspray, mouthwash, aftershave, etc.					
Marijuana: E.g., pot, hash, hash oil, shatter, etc.					
Cocaine: E.g. Crack, powder					

SUBSTANCE Circle specific substance(s) or print name	**Pattern & Frequency of Use** In last 6 months: Occasional, Daily, Weekly, Monthly, Binge, Other	**Method of Use** N = nasal/ snort O = oral/ swallow IV = inject IS = inhale/ smoke	**Average Amount Used** In a 24-hour period)	**Length of Time Used** In days, months, years	**Date Last Used** Include time if known
Inhalants/Solvents: E.g. Lacquer, glue, paint thinner, gasoline, aerosol sprays, amyl nitrate, etc.					
Club Drugs: E.g. Ecstasy (MDMA), GHB, Rohypnol, Ketamine, etc.					
Hallucinogens: E.g. Psilocybin mushrooms, LSD, Peyote, PCP (Angel Dust), Mescaline, DMT					
Amphetamines: E.g. Crystal meth, speed, pint					
Illicit Street Opiates: E.g. Heroin, Opium					
Fentanyl & Analogues					
Prescription Opioids: E.g. Codeine (T-2s, T-3s,) Oxycodone (Percodan®, Percocet®), Hydrocodone (Lortab®, Lorcet®) Dilaudid®, Darvon®, Morphine, Demerol®, etc.					
Prescription Sedatives, Tranquilizers, Barbiturates, Benzodiazepines E.g. Valium®, Ativan®, Serax®, Rivotril®, Halcion®, Librium®, Xanax®, Mogodon®, Nembutal®, Luminal®, Ambien®, etc.					
Prescription Stimulants: E.g. Ritalin®, Dexedrine®, Adderall®, Concerta®, etc.					
Gabapentin (Neuronton®)					
Over the Counter Drugs: E.g. Codeine (T-1s), Gravol®, Cough Syrup with Dextramethorphan (DXM) etc.					
Anabolic Steroids					

Substance(s) of choice	1.	2.	3.

D. WITHDRAWAL SYMPTOMS

Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptom			**Describe**
Blackouts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Hallucinations	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	

Symptom			Describe
Nausea/vomiting	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Seizures	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Shakes	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Delirium Tremens (DTs)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	

E. PROCESS/BEHAVIOURAL ADDICTIONS

Has the client experienced problems with any of the following?

Process/Behavioural Addiction			Describe
Gambling (slots, cards, Keno, bingo etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Sex (promiscuity, etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Internet, texting	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Other	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Other	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	

F. MENTAL HEALTH ISSUES

Provide the following information about the client's mental health status:

Mental Illness			Description
Been diagnosed with mental illness(es)	☐ Yes ☐ No	☐ Unknown	If yes, is medical documentation attached? ☐ Yes ☐ No ☐ Not applicable
Currently being treated for mental illness(es)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, what treatment is being provided and by whom?
Currently on psychiatric medication	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, describe medication.

Taking medication consistently	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	Please describe.
Previous suicide attempts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, when? Please describe.
Hospitalized for suicide attempts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, when? Please describe.
Currently suicidal	☐ Yes ☐ No	☐ Unknown	If yes, for how long? Please describe.

G. OTHER ISSUES/NEEDS

Provide information about other client issues and needs:

Describe client’s cultural and/or spiritual beliefs and practices that we need to be aware of.
Describe client’s personal strengths:
Describe other significant issues we need to be aware of.

H. APPLICATION CHECKLIST

Item	Response
Confirmation of transportation to Treatment Centre through referral	☐ Yes ☐ No
Confirmation of transportation back home	☐ Yes ☐ No
Client understands there is an expectation to be alcohol and drug free for at least 7 days prior to admission to residential treatment (or 14 days if withdrawing from benzodiazepines). (Clients with less than the required days must notify the treatment centre prior to admission).	☐ Yes ☐ No
Client understands there is an expectation of completion of a minimum of four aftercare counselling sessions upon completion of residential treatment.	☐ Yes ☐ No

Client has been informed about the following personal items needed to bring or leave behind on entering treatment:

Things to Bring	**Things to Leave Behind**
✓ Toiletries (toothbrush, toothpaste, shampoo, deodorant, etc.) ✓ Bathing suit and shorts ✓ Warm clothing (boots, coat, hat, gloves, etc.) ✓ 2 pairs of running shoes for indoor/outdoor activities ✓ Towel and facecloths ✓ Pajamas and slippers ✓ Personal items (e.g. feminine hygiene products) ✓ Medications (All non-prescription and physician prescribed medication MUST be handed in to intake worker upon arrival and must be in SEALED, ORIGINAL PACKAGING). Bubble packed medication is preferred. ✓ Tobacco/nicotine replacement products ✓ Money ✓ Valid identification card ✓ Provincial health card(s) or photocopy of health card	× Electronic devices (e.g. Computers/laptops, tablets) × Food × Workout supplements × Beverages including energy drinks × Items specified by the treatment centre **NOTE: Cell phones will be locked up during client's stay in treatment.** **NOTE: The decision to lock up other items during the client's stay in treatment is at the discretion of the individual treatment centre.**

CLIENT AUTHORIZATION

I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by the Treatment Centre.

Client Signature ______________________ Date (D/M/Y) ______________

Referral Signature ______________________ Date (D/M/Y) ______________

PART 2 – REFERRAL INFORMATION

Referral Worker Name:		Title:	
Agency:		Telephone:	
Fax:		Email:	
Address:			

Will you continue to see the client once he/she has completed treatment? ☐ Yes ☐ No

If no, please explain:

List supports and programs available to support recovery after your client leaves treatment (for aftercare planning).

Name/Resource	**Description of Support**

Briefly summarize all assessment processes completed with the client (e.g. CAGE, Audit, Socrates, Treatment Readiness, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, social, psychological, spiritual, emotional**). Include assessment scores and interpretations**. Attach a separate sheet if necessary or the assessment summary from your client file.

CLIENT'S STAGE OF READINESS

☐ Pre-contemplation - Not considering change; resistant to change

☐ Contemplation - Unsure of whether or not to change; chronic indecision

☐ Determination - Preparation; committed to changing behavior within one month

☐ Action – Begin changing behaviour

☐ Maintenance - Behaviour change has persisted for 6 months or more

Please list any questions or concerns the client has indicated during the intake process.

What other areas might need to be addressed in treatment? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.)

Referral Agent assessment of client's strengths and potential challenges for completing treatment.

REFERRAL CHECKLIST

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

Item	Attached	Initials
Psychiatric evaluations	☐	
Probation order	☐	
Current Medical Assessment form	☐	
Assessment Summary	☐	
Substance Abuse Profile	☐	

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 treatment.	
All financial matters have been dealt with prior to treatment.	
All legal matters have been dealt with prior to treatment.	

Referral's Signature

Date (D/M/Y)

PART 3 – MEDICAL ASSESSMENT

Note: This form may be substituted with the medical assessment in the Alberta Health Services Residential Adult Addiction Treatment Program Application form (pp. 7-9) http://www.albertahealthservices.ca/frm-18020.pdf

All clients must have this form completed by a physician, nurse practitioner or registered nurse. 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. Payment will depend on client attending treatment. The invoice must include the client's treaty number 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 honored. To protect client confidentiality please do not attach this assessment to the invoice.

Applicant's name:		Health Care Number:	
Treaty Number (10 digits)		Are you the client's regular physician?	☐ Yes ☐ No

A. Medical History: (explain any 'yes' responses in Section B)

	Diagnosed		Tested		Comments
	Yes	**No**	**Yes**	**No**	
Central Nervous System Disorder	☐	☐	☐	☐	
Chronic bronchitis	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Heart problems	☐	☐	☐	☐	
Gastrointestinal problems	☐	☐	☐	☐	
Pancreatic problems	☐	☐	☐	☐	
Kidney or urinary problems	☐	☐	☐	☐	
Diabetes / hypoglycemia	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
Chronic pain	☐	☐	☐	☐	
Eating disorders	☐	☐	☐	☐	
Sleep disorders	☐	☐	☐	☐	
Withdrawal symptoms, seizures, etc.	☐	☐	☐	☐	
Mood disorders (e.g., major depressive disorder)	☐	☐	☐	☐	
Psychotic disorders (e.g., schizophrenia)	☐	☐	☐	☐	
Personality Disorders	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	
Liver problems: Hepatitis B & C	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
Sexually Transmitted Infections	☐	☐	☐	☐	
Medical confirmation of pregnancy	☐	☐	☐	☐	# weeks
Is all related testing complete? ☐ Yes ☐ No	If no, please describe				
Are there any special considerations regarding the pregnancy and pre-natal care we need to be aware of?					
Current blood pressure:					

Any other medical problems not listed:

B. Are there any specific problems that should be considered in the treatment of this applicant?

C. Current Medications

Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. (Current computer printed attachment is acceptable.) Please note no mood-altering medications will be allowed in residential treatment unless prescribed and monitored by a psychiatrist for management of a mental illness.

DRUG NAME	DOSE/SCHEDULE	LENGTH OF TIME USED	CONSISTENT USE?	CLINICAL INDICATION
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Reminder to physician: For the applicant's safety and wellness while in residential treatment, please arrange with his or her pharmacy for compliance with packaging of medication to take to treatment and prescribe sufficient quantities for duration of treatment.

Is the applicant stabilized on medication? ☐ Yes ☐ No

In the past 6 months has the client been using the medication appropriately? ☐ Yes ☐ No

If no, please explain:

Physician's Name:	Telephone:
Date:	Address
PRAC ID:	Fax #:

Physician's Signature

Date (D/M/Y)

Physician's Stamp: