



PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED
INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS.

Form to be completed by referring agent.
If any information is NOT APPLICABLE = NA,
UNKNOWN = UNK and
UNAVAILABLE = UNA.

Attach a separate sheet of paper if more room is needed.

DAY PROGRAM

ADULT INTAKE/REFERRAL APPLICATION

<u>GENERAL INFORMATION</u>			
Surname:	First Name:	Middle Name:	Nickname/AKA:
Date of Birth:	Age:	Sex:	Provincial Health Card Number
Address:			Postal Code:
Email Address:			Telephone:
Language Spoken:	Language Preferred:	Language Understood:	
Emergency Contact Name:		Telephone:	Relationship to client:
Status Indian: Y N	Treaty/Band Number:		Band Name:
Education:	Literacy Level:	Employment Status:	

<u>FAMILY / RELATIONSHIPS</u>			
Marital Status:			
Does Client have dependent children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, do they have access to adequate childcare while in treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
Are the children in care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
Does the client have other dependents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
Provide information on client's children or other dependents:			
Name	Age	Relationship	

RISING SUN TREATMENT CENTER

31 Riverview Rd. W., Eel Ground First Nation, NB. PH#: 506-627-4626 / FAX#: 506-627-4627

Father's Name:	Deceased?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Community:
Mother's Name	Deceased?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Community:
Family Supports:			
Family Strengths:			

<u>LEGAL STATUS</u>			
Has client been court ordered to attend treatment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES , provide details (include details/copy of Probation Order if applicable and/or available):			
Most Recent involvement in the justice system at entry:	<input type="checkbox"/> Criminal Court	<input type="checkbox"/> Court Referral	
	<input type="checkbox"/> Family Court	<input type="checkbox"/> Court Order	
	<input type="checkbox"/> Drug Court Treatment	<input type="checkbox"/> Restorative Justice	
	<input type="checkbox"/> Probation	<input type="checkbox"/> Mental Health	
	<input type="checkbox"/> Charges Pending	<input type="checkbox"/> No Involvement	
		<input type="checkbox"/> Unknown	
Is the client under any of the following legal conditions?	<input type="checkbox"/> Bail	<input type="checkbox"/> Parole	<input type="checkbox"/> Temporary Absence Order
Other (provide details, dates, etc.):			
Does this client have any previous charges/convictions?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details:			

<u>TREATMENT HISTORY</u>				
Had client participated in a non-residential /community-based substance abuse program, such as Outpatient, or Day program?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Had client participated in a non-residential /community-based substance mental health program?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type of program(s):				
Has client participated in an in-patient residential treatment program before?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide information on previous treatment experience:				
YEAR	TREATMENT CENTRE	TYPE OF ADDICTION	COMPLETED	COMMENTS
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Reason(s) for currently requesting treatment:

WITHDRAWAL SYMPTOMS

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

Symptoms		Describe
Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Hallucinations (Audio/Visual)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Shakes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Delirium Tremens (DT's)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Ever experienced DTs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

PROCESS/BEHAVIORAL ADDICTIONS		
HAS CLIENT EXPERIENCED PROBLEMS WITH ANY OF THE FOLLOWING?		
Process/Behavioral Addiction		Describe
Gambling (slots, cards, Keno, bingo, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Eating (obesity, anorexia, bulimia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Sex (promiscuity, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Internet/texting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Gaming	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Social Media	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

<u>MENTAL HEALTH ISSUES</u>				
Provide the following information about the client's health status:				
Mental Illness		Describe		
Been diagnosed with a mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Currently being treated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Currently on psychiatric medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Taking medication consistently	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Previous suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
If yes, when?				
Hospitalized for suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
If yes, when?				
Currently suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Unknown
Name of psychiatrist/psychologist (if applicable):				
<u>E. OTHER ISSUES/NEEDS</u>				
Does client have cultural and/or spiritual beliefs and practices we need to be aware of?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:				

Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:	
Are there any other significant issues we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:	
Does client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does client understand there is an expectation they have been alcohol and drug free for at least 7 days prior to admission to residential treatment (or 14 days if withdrawing from benzodiazepines). (Client with less than the required days must notify the treatment centre prior to admission).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Strengths:	

F. APPLICATION CHECKLIST

With confirmation of attendance, the Non-Insured Health Benefits policy will be to reimburse for travel through the Health Centre Transportation Coordinator. My current plan is:	<input type="checkbox"/> Own vehicle <input type="checkbox"/> Someone will drive me <input type="checkbox"/> Medical Driver <input type="checkbox"/> Unsure
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Client Authorization

I authorize the documentation of my information for this application process to be used with the AMIS data base. This includes the transferring of files.	Initial
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I understand and agree to accept the treatment program as described by the Treatment Centre.	Initial
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Client Signature	Date
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Referral Signature & Contact Information	Date
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REFERRAL INFORMATION

Has the client completed four pre-treatment appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Please provide appointment dates:	Date 1:	Date 2:	Date 3:	Date 4:
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Will you continue to see the client once he/she has completed treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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What other supports would be available to your client in their community upon completion of treatment?

Name/Resource	Description of Support

PRESENT LIVING SITUATIONS:

<input type="checkbox"/> Lives Alone, own place	<input type="checkbox"/> Lives with Parents	<input type="checkbox"/> Single Parent	<input type="checkbox"/> With Spouse & Children	<input type="checkbox"/> Common law	<input type="checkbox"/> Other	<input type="checkbox"/> No Home
Are these living arrangements shared:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, with whom:			
Do you have a family member working at the Rising Sun?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who:			

Please provide/attach a brief assessment summary, (Assessment Summaries completed within 6 weeks of this application may be substituted and attached) including summarization of any assessment processes completed with the client (e.g. SASSI, MAST, DAST, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, school, psychological, spiritual, emotional).

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 behavior
- Maintenance - Behavior 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:

<u>REFERRAL CHECKLIST</u>		
Please initial which applicable items have been completed. Check off any items attached to this application:		
Item	Attached	Initials
Psychiatric evaluations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Probation order	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Medical Assessment Forum	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assessment Summary (DUSI-R) See attached	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Profile	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>PLEASE INITIAL EACH ITEM THAT HAS BEEN COMPLETED:</u>		
Item	Initials	
Confirmation of transportation to/from the treatment center		
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 Signature	Date (DD/MM/YY)	

PLEASE NOTE: During their stay at the Rising Sun Treatment Program
The Thunderbird Assessment tool will be utilized for pre & post treatment evaluation.

Date of Completion DD _____ MM _____ YYYY _____