

LONE EAGLE HEALING CENTRE

491 GRAHAM ROAD
ELSIPOGTOG, NB, E4W 2T8
(P) 506 523 8244 (F) 506 523 8242

APPLICATION FOR ADMISSION

**** FORMS TO BE COMPLETED BY REFERRING PERSON**

NAME:

FIRST

MIDDLE

LAST

ADDRESS:

STREET

CITY

PROVINCE

POSTAL CODE

PHONE:

HOME

CELL

WORK

SEX: F M

DATE OF BIRTH:

AGE:

MM/DD/YYYY

MARITAL STATUS:

SINGLE

MARRIED

DIVORCED

COMMON LAW

SEPERATED

HERITAGE:

MICMAC

MALISEET

INNU

INUIT

OTHER – SPECIFY:

BAND NAME:

BAND NUMBER:

10-DIGIT

LANGUAGE:

LEGAL STATUS:

ADULT

YOUTH

MEDICARE #:

NUMBER

EXPIRY DATE

NB

NS

PEI

NFLD

EMPLOYED:

YES

NO

IF YES, OCCUPATION:

NEXT OF KIN TO BE NOTIFIED IN CASE OF EMERGENCY:

NAME:

RELATIONSHIP:

FIRST

LAST

ADDRESS:

STREET

CITY

PROVINCE

POSTAL CODE

PHONE:

HOME

CELL

WORK

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FAMILY BACKGROUND

Does client have dependent children?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, do they have access to adequate childcare while in treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<input type="checkbox"/> N/A	
Are any children under youth protection or social services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<input type="checkbox"/> VOLUNTARY MEASURES	
	<input type="checkbox"/> COURT ORDERED	
	<input type="checkbox"/> N/A	
Does the client have other dependents?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Provide information on client's children or other dependents:		
<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>

PARENTS INFORMATION

<u>MOTHER</u>			
NAME:		AGE:	RELIGION:
FIRST	LAST		
IF DECEASED, DATE OF DEATH:		CAUSE OF DEATH:	
MM/DD/YYYY			
ADDRESS:			
STREET	CITY	PROVINCE	POSTAL CODE
PHONE:	HERITAGE:	RELIGION:	

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FATHER			
NAME:		AGE:	RELIGION:
FIRST	LAST		
IF DECEASED, DATE OF DEATH:		CAUSE OF DEATH:	
MM/DD/YYYY			
ADDRESS:			
STREET	CITY	PROVINCE	POSTAL CODE
PHONE:	HERITAGE:	RELIGION:	

SIBLINGS

FIRST NAME	LAST NAME	AGE
What kind of relationship do you have with your... Parents: _____ Spouse: _____ Brothers: _____ Sisters: _____ Friends: _____ God/Creator/Higher Power: _____ What are your views on Authority? _____		

EDUCATION

Highest grade completed: _____ College/Trade/Post-secondary Education: _____

MILITARY

DATE ENLISTED:	DATE DISCHARGED:
MM/DD/YYYY	MM/DD/YYYY
COMMENTS: _____	

RELIGIOUS AFFILIATION: (check your religion)	

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<input type="checkbox"/> Traditional	<input type="checkbox"/> Catholic	<input type="checkbox"/> Methodist	<input type="checkbox"/> Episcopalian	<input type="checkbox"/> Anglican	<input type="checkbox"/> Baptist
<input type="checkbox"/> Lutheran	<input type="checkbox"/> Other: _____				

HOME SITUATION

What is your home situation? Explain _____

How was alcohol/drugs/prescription drugs affected you personally? Explain _____

Has alcohol/drugs/prescription drugs affected your standing and/or relationship with your community? Explain if yes:

LEGAL HISTORY

Has client been court ordered to attend treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation Order/Parole Conditions attached? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the name of probation officer: _____
Is client currently incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain charges: _____ _____	
Is the client under any of the following legal conditions? <input type="checkbox"/> Bail <input type="checkbox"/> Parole <input type="checkbox"/> Probation <input type="checkbox"/> Temporary Absence Order <input type="checkbox"/> Other If other, please explain (provide details, dates, etc.): _____ _____	

Have you been convicted of a violent offense? Yes No Sexual offense? Yes No

If yes, type of offense: _____ Time served: _____ Dates: _____

Any pending charges? Yes No If yes, please provide court dates: _____

If charges are pending, can court be set over until completion of treatment? Yes No

Are you a victim of any physical assault? Yes No
If yes, when? _____ Where? _____

Who assaulted you? (ex: friend, stranger, husband, wife, etc.): _____

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If you are in a treatment program and the person who assaulted you arrived at the same program, what would you do?
Explain: _____

MENTAL HEALTH

Do you have a history of psychological difficulties (Ex: depression, anxiety, etc.), that required professional counselling?
 Yes No If yes, please explain: _____

Have you ever been hospitalized for psychological reasons? Yes No
If yes, when: _____ Where: _____ How long: _____

Have you ever been prescribed medication for psychological reasons? Yes No
If yes, name of medication(s): _____

Did you take the medication as prescribed? Yes No If no, please give reasons for not following the
prescription? _____

Have you ever had thoughts of suicide? Yes No If yes, what kind of thoughts? _____

Did you have a plan? Yes No If yes, please explain: _____

Have you ever attempted suicide? Yes No If yes, when? _____ How? _____ # of times _____

Were you hospitalized due to these attempts? Yes No If yes, where? _____ How long? _____

Do you know someone who has committed suicide? Yes No
If yes, what relationship did they have with you? _____

Do you ever have thoughts of wanting to hurt someone? Yes No
If yes, have you ever acted out these thoughts, explain: _____

Were you using alcohol/drugs at the time? Yes No

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SUBSTANCE USE HISTORY

SUBSTANCE <small>Circle specific substance(s) or print name</small>	PATTERN & FREQUENCY OF USE <small>In last 6 months: Occasional, Daily, Weekly, Monthly, Binge, Other</small>	METHOD OF USE <small>N = nasal/snort O = oral/swallow IV = inject IS = inhale/smoke</small>	AVERAGE AMOUNT USED <small>In a 24 hour period</small>	LENGTH OF TIME USED <small>In days, months, years</small>	DATE LAST USED <small>Include time if known</small>
Alcohol: beer, wine, coolers, liquor, homebrew, Lysol, hairspray, mouthwash, aftershave, etc.					
Marijuana: pot, hash, hash oil, shatter, etc.					
Cocaine: Crack, powder					
Inhalants/Solvents: Lacquer, glue, paint thinner, Hasoline, aerosol sprays, amylnitrate, etc.					
Club Drugs: Ecstasy (MDMA), GHB, Rohypnol, Ketamine, etc.					
Hallucinogens: Psilocybin, mushrooms, LSD, Peyote, PCP(Angel Dust), Mescaline, DMT					
Amphetamines: Crystal meth, speed, pint					
Illicit Street Opiates: Heroin, Opium					
Fentanyl & Analogues					
Prescription Opioids: Codeine(T-2's, T-3's), Oxycodone (Percodan, Percocet), Hydrocodone(Lortab, Lorcet) Dilaudid, Darvon, Morphine, Demerol, etc.					
Prescription Sedatives, Tranquilizers, Barbituares, Benzodiazepines: Valium, Ativan, Serax, Rivotril, Halcion, Librium, Ambien, etc.					
Prescription Stimulants: Ritalin, Dexedrine, Adderall, Concerta, etc.					
Gabapentin (Neuronton)					
Over the Counter Drugs: Codeine (T-1's), Gravol, Cough Syrup with Dexamethorphan (DXM)					
Anabolic Steroids					

Substance(s) of Choice	1.	2.	3.
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WITHDRAWAL SYMPTOMS

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

Symptom		Describe
Blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hallucinations	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nausea/Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Shakes	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Delirium Tremens (DT's)	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

BEHAVIOURAL ADDICTIONS

Has client experienced any problems with any of the following?

Behavioural Addiction		Describe
Gambling (Slots, cards, keno, bingo, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Eating (Obesity, anorexia, bulimia, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Sex (Promiscuity, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Internet, texting, social media	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

TREATMENT HISTORY

Has client participated in a non-residential community-based substance abuse and/or mental health program? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, describe program(s):				
Is client currently prescribed: Methadone: <input type="checkbox"/> Yes <input type="checkbox"/> No Suboxone: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____				
If yes, please provide information on most recent treatment experiences:				
YEAR	TREATMENT CENTRE	TYPE OF ADDICTION	COMPLETED	COMMENT
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe client's reason(s) for currently requesting treatment: _____				

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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 (CAGE, Audit, SASSI, DUSI-R, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (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.

CLIENTS STAGE OF REDINESS

Pre-contemplation	Not considering change; resistant to change
Contemplation	Unsure of whether or not to change; chronic indecision
Determination	Preparation; committed to changing behaviour within one month
Action	Begin changing behaviour
Maintenance	Behaviour change has persisted for 6 months or more

What brought you to seek treatment at this time?

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

What do you hope to gain while attending Lone Eagle Healing Center?

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REFERRAL CHECKLIST

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

ITEM	Attached	Initials
Psychiatric evaluations	<input type="checkbox"/>	
Probation order	<input type="checkbox"/>	
Current Medical Assessment Form	<input type="checkbox"/>	
Assessment Summary	<input type="checkbox"/>	
Substance Abuse Profile	<input type="checkbox"/>	

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

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	

THINGS TO BRING	THINGS TO BE LEAVE BEHIND
<ul style="list-style-type: none"> ○ Toiletries (toothbrush, toothpaste, shampoo, deodorant, etc.) ○ Warm clothes (boots, coat, hat, gloves, etc.) weather permitted ○ 2 pairs of running shoes for indoor/outdoor activities ○ Towel and facecloths ○ Pajamas and slippers ○ Personal items (feminine hygiene products) ○ Medication (All non-prescription and physician prescribed medication MUST be handed in to intake worker upon arrival and must be SEALED, ORIGINAL PACKAGING) Blister packed medication is preferred. ○ Tobacco/nicotine replacement products ○ Money ○ Valid identification card ○ Provincial health card(s) or photocopy of health card 	<ul style="list-style-type: none"> ○ Electronics ○ Vape Pens

Referral Signature

PRINT

SIGN

DATE DD/MM/YYYY

Client Signature

PRINT

SIGN

DATE DD/MM/YYYY