Alberta Health Services

Office Use Only	Client ASIST #

Residential Gambling Treatment Program Application

Submit completed Application to Northern Addictions Centre by **mail** to 11333-106 Street, Grande Prairie, AB T8V 6T7 or **fax** to 780.538.6313. **Call** 780.538.6350 for inquiry.

Please **Print clearly** and answer **all** questions in detail. Unanswered, incomplete or illegible responses will delay your admission.

Client Information

1. What is your legal name?
   (last) _____ *(first)* _____ *(middle)* _____
2. What name do you like to be called?
3. Is there another name that you use or have used? Example, your maiden name or alias?
   (last) _____ *(first)* _____ *(middle)* _____
4. Mailing Address *(street)* _____
   (city) _____ *(province)* _____ *(postal code)* _____
5. Three months ago, were you a resident of the province of Alberta? ☐ Yes ☐ No
6. If no, when did you take up residency in Alberta?
   Date *(yyyy-Mon-dd)* _____ *(Proof of residency may be required.)*

7. Home Phone	Alternate or Cell Phone	Fax

8. ☐ Male ☐ Female	Age	Date of Birth *(yyyy-Mon-dd)*	Personal Health Number

9. What is your highest grade completed?
   ☐ None ☐ Grade 7 ☐ Grade 9 ☐ Grade 11 ☐ College/Technical Diploma
   ☐ Grade 1–6 ☐ Grade 8 ☐ Grade 10 ☐ Grade 12/13 ☐ University Degree
10. What is your marital status? *(Check only ONE box that best applies to you)*
    ☐ Single/Never Married ☐ Widowed ☐ Divorced
    ☐ Married/Common-law/Partnered ☐ Separated
11. What is your current employment status?
    ☐ Unemployed ☐ Employed Part-time ☐ Disability
    ☐ Employed Full-time ☐ Self-Employed ☐ Other
12. What is your usual occupation?
    ☐ Professional/Management ☐ Fishing/Hunting/Trapping ☐ Homemaker
    ☐ Clerical/Library ☐ Manufacturing/Construction ☐ Forestry/Mining/Oil
    ☐ Sales/Service ☐ Transportation/Equipment Operator ☐ Other
    ☐ Agriculture ☐ Arts/Culture/Recreation
13. Cultural Identify: The following question is asked in order to improve its services to individuals from a variety of cultural/ ethnic backgrounds. If you identify yourself with a particular ethnic or cultural group(s), please tell us which one(s).
    ☐ Aboriginal ☐ Other *(specify)* _____
    ☐ I do not identify with any ethnic or cultural group.
14. If your application was prompted, please check all that apply
    ☐ Addiction Services Office ☐ Physician ☐ Child Welfare Worker
    ☐ Psychiatrist/Psychologist/Mental Health Worker ☐ Addiction Funded Agency
    ☐ Employer/Employee Assistance Program ☐ Social Services/Income Support Worker
    ☐ Court/Parole Office/Probation Officer/Lawyer
    ☐ Other *(specify)* _____

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Application for the Residential Gambling Treatment Program

1. Favourite gambling activity *(e.g. VLT, Bingo, Horse racing)*?

2. How long have you been playing the above types of gambling?

3. How long have you recognized gambling as a problem?

4. What other forms of gambling have you tried in your lifetime?

5. What are your main concerns about gambling at this time?

6. When did you last gamble?

7. What is the average amount you have spent gambling on one occasion?

8. How often do you usually gamble? *(Daily, weekends, paydays)*

9. What do you hope to get out of this program?

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10. What effects have you experienced in your major life areas as a result of gambling behaviour?

☐ Family *(Partner/Children, Extended Family Support, Concerns)*

☐ Relationships/Social Life *(Safe Living, Friendships, Support)*

☐ Employment *(Career Choices, Employer Awareness, Job Loss/Missed)*

☐ Financial *(Stable Income, Financial Damage)*

☐ Education *(Level Achieved, Goals)*

☐ Physical Health *(Pregnancy, Chronic Problems)*

☐ Legal *(Pending Charges, Convictions, Sentences, Probation)*

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☐ Emotional / Psychological *(Feelings)*

☐ Spiritual *(Importance, Difficulties)*

☐ Leisure *(Interests, Activities)*

Alcohol and/or Other Drug Use Information

1. Have you ever had a problem with drugs or alcohol? If so, what did you use and how often?

2. Date of last alcohol / drug use *(yyyy-Mon-dd)* and amount _____

3. Have you previously attended residential treatment for substance abuse or gambling?
   ☐ No ☐ Yes
   a. If yes, check all you've attended.
      ☐ NAC ☐ Henwood ☐ Lander ☐ Business and Industry Clinic
      ☐ Other treatment agencies attended *(List below)*
   b. What addictions were addressed in previous treatment?
   c. Approximate date(s)
   d. How long did you remain alcohol, drug or gambling free after treatment?

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Psychological and Emotional Functioning

1. Currently or in the past, have you seen a doctor, psychologist or counsellor for:

   ☐ anxiety ☐ depression ☐ panic attacks
   ☐ hallucinations ☐ uncontrollable anger ☐ other

   If yes, please describe in detail:

   a. What condition(s)? _____

   b. When did treatment(s) occur *(Month/Year)* _____

   c. What treatment was received and results?

   _____

   _____

   d. Are you presently being treated for this condition? ☐ No ☐ Yes

2. Have you ever thought about harming yourself? ☐ No ☐ Yes

   If yes, when? *(Month/Year)* _____ / _____

   Was it related to your gambling and/or alcohol/drug use? ☐ No ☐ Yes

3. Have you ever attempted suicide? ☐ No ☐ Yes

   If yes, by what means?

   _____

   _____

   When was your last attempt? _____

4. If you are currently under the care of a doctor, psychiatrist or psychologist, please give name and phone number _____

Individual Overview

Please use the following space to share your story. You can make it as detailed or brief as you feel comfortable. Any questions, concerns or fears you have can be written here. Please free to attach additional paper if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Individual Overview *continued*

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Psychological and Emotional Functioning

Do you have any special needs / problems that we should be aware of – such as reading and writing, dietary, wheelchair accessibility, hearing difficulties, problems with stairs and corridors?

☐ No ☐ Yes If yes, please give details

A room and board fees of **$40.00 per day for Alberta residents and $125.00 per day for out of province residents.**

Please indicate method of payment

☐ Cash ☐ Certified Cheque ☐ Money Order ☐ Visa ☐ MasterCard
☐ Social Services ☐ Health Canada / Indian Affairs
☐ Other, please explain _____

Social Services Number _____ Treaty Status Number _____ Band Number _____

Carefully Read the Following

- I understand in order to be admitted to residential treatment, I **must** remain gambling, alcohol and drug free for at least five days prior to my admission date, and be well enough to participate in the program. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be referred to an appropriate detoxification setting before treatment.
- I understand Alberta Health Services (AHS) is not responsible for my transportation or any other personal costs I may incur (e.g. approved medications) while I am in treatment. I will bring and give to staff all medications I am taking.
- I understand I **cannot** schedule **any** appointments (legal, dental, medical or personal) for the period while in treatment. I must focus on my treatment program.
- I understand and agree to accept and attend all components of the treatment program as prescribed by AHS, including all workshops, lectures, leisure and group counseling sessions.

Applicant's Signature	Date *(yyyy-Mon-dd)*

I give permission to AHS to disclose my name in order to obtain further information that is necessary to determine my suitability for residential treatment, confirm my method of Room and Board payment and/or to confirm that I will be reporting for residential treatment as scheduled.

Applicant's Signature	Date *(yyyy-Mon-dd)*

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To be completed by Referring Counsellor/Agency. Please print clearly.

Referring Person's Name

Agency

Professional Relationship to Applicant

Business Address

Postal Code	Fax	Phone

Type of Referral *(Check the box which most applies)*

- ☐ AHS Addiction Office
- ☐ Other Addictions Agency
- ☐ Relative/Friend
- ☐ Pastoral
- ☐ Justice Legal
- ☐ Other _____
- ☐ Health/Medical – Doctor
- ☐ Health/Medical – Other
- ☐ Mental Health
- ☐ Justice Legal
- ☐ WCB/Disability Management
- ☐ Business/Workplace, specifically
  - ☐ Employee Assistance Program (EAP)
  - ☐ Occupational Health
  - ☐ Human Resources
  - ☐ Private Employer

What is your assessment of the applicant's readiness and motivation for Residential Gambling Treatment?

Referring Person's Signature	Date *(yyyy-Mon-dd)*

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Alberta Health Services

Residential Adult Addiction Treatment Program Application

This medical assessment is required as part of the application and must be completed in full by a medical doctor or nurse practitioner. The cost of fully completing this medical is covered by Alberta Health Care.

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	Personal Health Number

Allergies *(e.g. drug, food medical tape, other)*

Review of Systems *(please send relevant reports, e.g. CBC, hepatic profile, electrolytes, urinalysis, fasting blood glucose)*

EENT

Respiratory *(e.g. asthma, COPD)*	Cardiovascular *(e.g. CVA, MI, HTN, arrythmia, pacemaker)*
Gastrointestinal *(e.g. GERD, history GI bleed, hepatitis, pancreatitis)*	Genitourinary *(e.g. incontinence, BPH, STD)*
Musculoskeletal *(e.g. chronic pain, RA, OA, gout)*	Integumentary *(e.g. psoraiasis, eczema)*
Neurological Does the patient have a history of seizures? ☐ No ☐ Yes	Hematological/Immune *(e.g. HIV+, HCV+)*
Evidence of withdrawal or intoxication? *(e.g. ETHO, OPIOID)*	Other *(specify)*

Physical Examination

Height	Weight	Temperature	Pupils	Heart Rate	Blood Pressure	Respiration Rate

Skin	Diaphoresis	Tremor

Is the patient diabetic? ☐ No ☐ Yes, complete this information ▶	Year diagnosed	Is the patient stable? ☐ No ☐ Yes
Does the patient have MRSA and wound? ☐ No ☐ Yes, specify latest swab results _____		Is there cognitive impairment? ☐ No ☐ Yes

Needs assistance ambulating or providing self care? ☐ No ☐ Yes

Pregnancy

Is the patient pregnant?	LMP	Para	Gravida		
☐ No, complete top boxes only ▶ ☐ Yes, complete **all** boxes ▶	EDC	Urine hCG	Prenatal blood work	Prenatal ultrasound	Blood type

Does the patient have current pregnancy complications or had a history of pregnancy complications?
☐ No
☐ Yes, specify _____

Physician managing the pregnancy and delivery	Phone	Fax

Address of planned location of delivery

Alberta Health Services

Residential Adult Addiction Treatment Program Application

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	Personal Health Number

TB Screening – Symptoms and History

Check the appropriate boxes	**No**	**Yes**
Presence of cough lasting more than 2 weeks		
Weight loss – if yes, specify _____ lbs. in _____ length of time		
Night sweats		
Fever		
Fatigue		
Haemoptysis *(blood in sputum)*		
Previous significant Mantoux or chest X-ray results		
Extensive travel *(or birth)* in a country with high incidence of TB		
Other risk factors *(i.e. aboriginal, elderly, homeless, health care worker)*		
Poor general health status and risk factors for progress of disease		
Further TB screening/assessment required – if **yes**, please send results to appropriate centre		

Medical Approval

In your opinion is this patient medically stable and appropriate for admission to Residential Addiction Treatment? ☐ No ☐ Yes

Physician or Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Psychiatric Review/History *(send psychiatric evaluations and/or discharge summaries if available)*

Addictions – note date of last use,pattern of abuse and severity of addiction *(e.g. alcohol, cocaine, opoids, cannabis, gambling, tobacco, etc.)*

Primary	Secondary	Tertiary

Is there evidence of the following? *(please include your judgement related to current severity of mental health concerns)*

	No	**Yes**	**Comments**
Mental, developmental and/or learning disorders *(e.g. depression,anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)*			
Underlying pervasive or personality conditions *(e.g. personality disorders, mental retardation)*			
Acute medical conditions and physical disorders aggravating mental health *(e.g. brain injury, cognitive impairment, chronic pain, insomnia)*			
Contributing psychosocial and environmental factors.			
Global Assessment of Functioning _____			
Is there a history of self-harm, suicidal thoughts or suicide attempts? ***(If yes, pertinent psychiatric reports/assessments are required)***			

Psychological Approval

In your opinion is this patient psychologically stable and appropriate for admission to Residential Addiction Treatment? ☐ No ☐ Yes

Physician or Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Alberta Health Services

Residential Adult Addiction Treatment Program Application

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	Personal Health Number

Medications *(if more room is needed, attach list. Send relevant laboratory results e.g. current INR, Lithium or Phenytoin levels)*

Medication	Dose	Route	Frequency	Reason given	Start Date	End Date	Prescribe by	Phone

Please remind patient that in order to be admitted to Residential Adult Addictions Treatment Program, they need to:

- Be well enough to participate in the program and remain **alcohol and drug free for at least five days prior** to admission.
- Ensure any new medications not listed above have been pre-approved by Treatment Program nurse.
- Bring enough of their medications (in the original packaging from the doctor or pharmacist) for their time in treatment.
- If the patient's medical or psychological condition changes before their scheduled admission date they must contact the Treatment Program.

Physician or Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*
Mailing Address		
City / Postal Code	Phone	Fax
Primary Physician Name *(if different than above)*	Phone	Fax
Other *(e.g. psychiatrist or other specialist relevant to this admission)*	Phone	Fax
Primary Care Network affiliation? ☐ No ☐ Yes, complete this information ▼		
Name	Address	

Physician Stamp