Alberta Health Services

Office Use Only
Client ASIST # _____

Residential Adult Addiction Treatment Program Application

A room and board fee of $40.00 per day for Alberta residents**,** $125.00 per day for out-of-province residents and $200.00 per day for clients attending the Business and Industry Clinic will apply.

Please complete pages one to five of this form and have the referring person *(if applicable)* complete page six. The medical assessment on pages seven to nine **must** be completed by a medical doctor or nurse practitioner. Return **all pages** by fax or by mail to the appropriate centre below. Unanswered questions, incomplete or illegible answers may delay your admission.

Please check the centre you are applying for. **You may only select one.**

☐ **Business and Industry Clinic**
11333 - 106 Street
Grande Prairie, AB T8V 6T7
Phone: 780.538.6316 **Fax:** 780.538.6313

☐ **Northern Addictions Centre**
11333 - 106 Street
Grande Prairie, AB T8V 6T7
Phone: 780.538.6350 **Fax:** 780.538.6313

☐ **Lander Treatment Centre**
P.O. Box 1330
221 - 42 Avenue West
Claresholm, AB T0L 0T0
Admissions: 403.625.5600
Switchboard: 403.625.1395 **Fax:** 403.625.1300

☐ **Henwood Treatment Centre**
18750 18 Street NW
Edmonton, AB T5Y 6C1
Admissions: 780.422.4466
Switchboard: 780.422.9069 **Fax:** 780.422.5408

☐ **Fort McMurray Recovery Centre**
451 Sakitawaw Trail
Fort McMurray, AB T9H 4P3
Phone: 780.793.8300 **Fax**: 780-793-8301

☐ **Medicine Hat Recovery Centre**
370 Kipling Street SE
Medicine Hat AB, T1A 1Y6
Phone: 403.529.9021 **Fax:** 403.529.9065

Legal name *(last, first, middle)*			
What name do you like to be called?	Other name *(e.g. maiden name or an alias)*		
Date of Birth *(yyyy-Mon-dd)*	Personal Health Number *(PHN)*	Age	☐ Male ☐ Female

Marital status *(Choose **one** only)*
☐ Single/Never married ☐ Married/Common-Law/Partnered ☐ Widowed
☐ Separated ☐ Divorced

Mailing Address		
City	Province	Postal Code
Home Phone	Alternate or Cell Phone	Fax Number

Three months ago, were you a resident of a province or territory other than Alberta?
☐ No
☐ Yes, what date did you take up residency in Alberta? (yyyy-Mon-dd) _____
(proof of Residency may be required)

What is your occupation?	Who is your employer?

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)* _____

Please describe in detail your alcohol, other drug use and/or gambling.

Regular Substance
What do you use most often?
Pattern of use *(e.g. daily, binge)*
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? *(yyyy-Mon-dd)*
Other Substance Used
What other drug do you use?
Pattern of use *(e.g. daily, binge)*
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? *(yyyy-Mon-dd)*
Other
What other drug have you used?
Pattern of use *(e.g. daily, binge)*
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? *(yyyy-Mon-dd)*
Gambling
Types of gambling done? *(e.g. VLT, bingo, horse gambling)*
Pattern of gambling *(e.g. daily, weekends, paydays)*
Amount of money gambled per occasion
How long have you gambled?
How long has this been a problem for you?
Date you last gambled? *(yyyy-Mon-dd)*

Describe in detail how your drinking, drug taking and/or gambling affected you and your life? *(e.g. effects on family relationships, employment, health, social life, etc.)*

Treatment history for alcohol, drug or gambling problems

Have you previously attended Alberta Health Services residential addictions treatment?

☐ No

☐ Yes, check all that you've attended below ▼

☐ Business and Industry Clinic ☐ Lander Treatment Centre ☐ Northern Addictions Centre

☐ Fort McMurray Recovery Centre ☐ Henwood Treatment Centre ☐ Medicine Hat Recovery Centre

Other treatment agencies attended

Reason(s) for previous treatment

Approximate date(s)

How long did you remain alcohol, drug or gambling free after treatment?

What are your reasons for wanting to attend residential treatment at this time?

Do you have any special needs or problems that we need to be aware of? *(e.g.reading and writing English, wheelchair accessibility, hearing difficulties, problems with stairs and long corridors)*

☐ No

☐ Yes, give details

Do you have any allergies? *(medications, foods, environmental)*

☐ No

☐ Yes, list them

List all medications that you are taking, including all over-the-counter drugs. *(e.g. Gravol, Tylenol, NyQuil, allergy medications, vitamins, herbal remedies, etc.)*

Are you seeing a doctor regularly for any reason, including just refilling medication?

☐ No

☐ Yes, explain _____

Describe current medical problems *(e.g. chronic health issues, recent surgery, injuries, pain, etc.)*

Have you ever experienced mental health concerns? *(e.g. panic attacks, hallucinations/delusions, uncontrollable rage, mood swings, mental illness, etc.)*

☐ No
☐ Yes, what are the problems? _____

Describe in detail how the above problems affected you or others both in the past and currently

If currently under the care of a doctor/psychiatrist/psychologist, complete boxes below ▼

Name	Phone Number

Have you had any thoughts of suicide or self-harm?

☐ No
☐ Yes, describe in detail

If you have a history of criminal convictions, list the type and approximate dates of conviction(s)

Describe any outstanding or pending legal charges

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If applicable, list upcoming court dates

Are you currently incarcerated/in jail?
☐ No
☐ Yes, which institution _____

Are you on Probation, Temporary Absence or Parole?
☐ No
☐ Yes, complete below ▼

Type of Offence	Name of Parole/Probation Officer
Parole/Probation Officer's Phone	Parole/Probation Officer's Agency/Office

Is there anything else you feel we should know?

Check method of payment

☐ Cash ☐ Certified Cheque ☐ Money Order ☐ Visa ☐ Mastercard
☐ Social Services,
If checked, provide 3rd party contact information _____
☐ Health Canada/Indian Affairs
If checked, provide 3rd party contact information _____
☐ Other *(explain)* _____

Carefully Read the Following

- I understand in order to be admitted to residential treatment, I **must** remain 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.

Signature	Date *(yyyy-Mon-dd)*

The personal information collected by this application is collected under the authority of section 33(c) of the Freedom of Information and Protection of Privacy Act and section 20 of the Health Information Act and will be used and disclosed by AHS for verifying the statements in this application and for determining admission to Residential Adult Addictions Treatment Program. If you have questions about this program please call one of the treatment centres. If you have any questions about AHS' privacy policies and practices, please contact Information and Privacy at 1-877-476-9874. You may also write to Information and Privacy at 10301 Southport Lane SW, Calgary, Alberta T2W 1S7 or email us at privacy@albertahealthservices.ca

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Please note you **can not** self refer to the Northern Addictions Centre. You must have a referring person to apply. All referrals must be on a professional basis; referrals from friends or family are not accepted.

☐ Self-referral, skip this section

This section is to be completed by the referring person only

Referring Person's Name		
Agency	Professional or Personal relationship to applicant	
Business Address	City	Province
Postal Code	Phone Number	Fax Number

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

☐ AHS Addiction Services
☐ Other Addictions Agency
☐ Relative/Friend
☐ Pastoral
☐ WCB/Disability Management
☐ Other *(specify)* _____

☐ Health/Medical – Doctor
☐ Health/Medical - Other
☐ Mental Health
☐ Justice Legal

☐ Business/Workplace, specifically:
- ☐ EAP
- ☐ Human Resources
- ☐ Occupational Health
- ☐ Private Employer

What is your assessment of the applicant's readiness and motivation for residential treatment?

Other than alcohol, drug or gambling, what issues does the applicant need to address while in the program?

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

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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 Care 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 ► *(need recent HbAIc result)*	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

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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 active TB and treatment		
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, opioids, 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)*

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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	Prescribed by	Phone number

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/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