Alberta Health Services

Addiction Treatment Application

Voluntary bed-based services are generally provided in a communal living setting with a cafeteria style dining area, recreational activities and group counseling sessions.

Return **all pages** by fax, mail, or email to the appropriate centre below. The information you provide is private. This information is used to find a program that fits your needs best.

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

☐ **Northern Addictions Centre**
11333 - 106 Street
Grande Prairie, AB T8V 6T7
Phone: 780.538.6350 **Fax**: 780.538.6313
Email: grandeprairieresidentialtreatment@ahs.ca

☐ **Lander Treatment Centre**
P.O. Box 1330
221 Fairway Drive
Claresholm, AB T0L 0T0
Phone: 403.625.1395 **Fax**: 403.625.1300

☐ **Medicine Hat Recovery Centre**
370 Kipling Street SE
Medicine Hat AB, T1A 1Y6
Phone: 403.529.9021 **Fax**: 403.529.9065
Email: medicinehatrecoverycentre@ahs.ca

☐ **Fort McMurray Recovery Centre**
451 Sakitawaw Trail
Fort McMurray, AB T9H 4P3
Phone: 780.793.8300 **Fax**: 780-793-8301
Email: FortMcMurray.RecoveryCentre@albertahealthservices.ca

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

Applicant Information

Legal Last Name	Legal First Name	Middle Name

Preferred Name	Date of Birth *(dd-Mon-yyyy)*	Administrative Gender
		☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

Have you lived in the province for more than three months?	Alberta Health Care *(ULI, PHN)*
☐ No ☐ Yes	

Permanent Address and Contact Details

☐ No Fixed Address ☐ Encampment ☐ Shelter ☐ Couch Surfing

☐ Address	City	Prov	Postal Code

Primary Phone	Email	Preferred Method of Contact
		☐ Phone ☐ Email

To find out if live-in treatment is right for you, we need to collect some information from you. Please share as much information as you can on the following pages. You may be asked to submit additional information after discussions with an intake person.

A. Substances of Concern

Substance	Substance use?	How important is it to you to change/stop using?
Alcohol	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Heroin, fentanyl, other non-prescribed opioid	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Prescription opioid	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Benzodiazepines/sleeping medication	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Cocaine/crack	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very

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A. Substances of Concern Continued									
Substance	**Substance use?**		**How important is it to you to change/stop using?**						
Methamphetamine	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Prescribed stimulant	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Cannabis/marijuana	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Nicotine/tobacco	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Other _____	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
B. Processes of Concern									
Concern Type	**Concern use?**		**How important is it to you to change/stop?**						
Gambling	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Sex addiction	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Pornography	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Video games	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Shopping	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		
Other _____	☐ Yes	☐ No	1 Not at all	2	3 Somewhat	4	5 Very		

C. Other Health Considerations *(Check 'yes' if any of the following concerns apply to you and may impact your treatment)*

Category	If yes, please tell us more
Mental Health ☐ Yes ☐ No	
Seizures ☐ Yes ☐ No	
Vision ☐ Yes ☐ No	
Hearing ☐ Yes ☐ No	
Heart ☐ Yes ☐ No	
Stomach/digestion ☐ Yes ☐ No	
Kidneys ☐ Yes ☐ No	
Liver ☐ Yes ☐ No	
Joint pain ☐ Yes ☐ No	

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C. Other Health Considerations Continued *(Check 'yes' if any of the following concerns apply to you and may impact your treatment)*	
Category	**If yes, please tell us more**
Movement/mobility ☐ Yes ☐ No	
Pregnancy ☐ Yes ☐ No	
Other ☐ Yes ☐ No	

D. Other Consideratons *(Check all that apoly)*		
Support Type	**Name**	**Contact Information**
☐ Family doctor		
☐ Spouse/partner		
☐ Child		
☐ Other family member *Relationship:* _____		
☐ Psychiatrist		
☐ Addictions counsellor		
☐ Other mental health professional *Relationship:* _____		
☐ Other		

E. Do you require any supports in treatment with:

☐ Reading _____

☐ Writing _____

F. Is there anyone you would like us to share information with about your application?

Name _____

Relationship _____

G. Please list any upcoming appointments, court dates, etc. that we need to know about when scheduling your treatment.	
Type of Appointment	**Date** *(dd-Mon-yyyy)* **and Time** *(hh:mm)*

Carefully read the following

- 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 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 *(dd-Mon-yyyy)*