Alberta Health Services

**Fort McMurray Recovery Centre**
**451 Sakitawaw Trail, Fort McMurray, AB, T9H 4P3**
**Phone 780-793-8300**
**Fax 780-793-8301**

# Day Treatment Program Application

Office Use Only
Client ASIST # _____

- Please note that you **cannot** self-refer to this Treatment Program.
- Referrals must be from AHS Addiction Services.
- Referrals from all other sources will **not** be accepted.
- Please complete pages one to five of this form and have the referring person complete page six.
- Return all pages by fax or by mail to the address above.
- Unanswered questions, incomplete or illegible answers may delay your admission.

| | | | |
|---|---|---|---|
| Legal Name (family, given, middle) | | | |
| Preferred Name? | 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 | ☐ Separated ☐ Married/Common Law/Partner | ☐ Divorced ☐ Widowed | |
| Mailing Address | | | |
| City | Province | Postal Code | |
| Home Phone | Alternate or Cell Phone | Fax Number | |
| What is your occupation? | Who is your employer? | | |

If your application was prompted, please check all that apply

- ☐ Addiction Services Office
- ☐ Child Welfare Worker
- ☐ Addiction Funded Agency
- ☐ Physician
- ☐ Social Services/Income Support Worker
- ☐ Employer/Employee Assistance Program
- ☐ Psychiatrist/Psychologist/Mental Health Worker
- ☐ Court/Parole Office/Probation Office Lawyer

**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)* |

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| **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?<br>*(e.g. effects on family relationships, employment, health, social life, etc.)* |
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| **Treatment history for alcohol, drug or gambling problems** |
| Have you previously attended Alberta Health Services residential addictions treatment? ☐ No |
| ☐ Yes *(check all that you have attended)*<br>☐ Northern Addiction Centre (NAC) ☐ Business and Industry<br>☐ Henwood ☐ Fort McMurray Recovery Centre (FMRC)<br>☐ Lander |
| Other treatment agencies attended |
| Reason(s) for previous treatment |
| Approximate date (s) |
| How long did you remain alcohol, drug or gambling free after treatment? |

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What are your reasons for wanting to attend 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, vision problems, 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 medications?

☐ 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, explain

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| Describe in detail how the above problems affected you or others, both in the past and currently. | |
|---|---|
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| If currently under the care of a doctor/psychiatrist/psychologist, complete the boxes below. | |
| Name | Phone Number |
| Have you had any thoughts of suicide or self-harm? | ☐ No |
| ☐ Yes, describe in detail | |
| | |
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| | |
| If you have a history of criminal convictions, list the type and approximate dates of conviction(s) | |
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| Describe any outstanding or pending legal charge. | |
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**Carefully Read the Following:**

- I understand in order to be admitted to treatment, I **must** have at **least five days** abstinence from alcohol, drugs, abuse of prescription medications and gambling before starting the program.
- 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 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© of the Freedom of information and Protection of Privacy Act and section 20 of the Health Informational Act and will be used and disclosed by AHS for verifying the statements in this application and for determining admission to Day Treatment Program. If you have questions about this program please call the treatment centre. 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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| **This section is to be completed by the referring source only.** | | | |
|---|---|---|---|
| Referring Person's Name | | Agency | |
| Business Address | | City | Province |
| Postal Code | Phone Number | | Fax Number |

| What is your assessment of the applicant's readiness and motivation for treatment? | |
|---|---|
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| Other than alcohol, drug or gambling, what issues does the applicant need to address while in the program? | |
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| ☐ Completed assessment form (e.g. SAGAA) attached. | |
| Referring Person's Signature | Date *(yyyy-Mon-dd)* |