



Adult Addictions Inpatient Treatment
REFERRAL APPLICATION
(Part I)



Name
HCN
Date of Birth

Please indicate if the below has been completed and attached:

- Assessment
- Medical Assessment
- Client Expectations Agreement
- Health Care Number

It is vital that **ALL** of the above information be received PRIOR to the assignment of an admission date. This will allow the individual access to an earlier admission date should there be a cancellation.

May a staff person telephone the client one week before his/her admission date to confirm his/her attendance, answer any questions they may have, and provide them with additional information about the program?

Yes No

If not at home, may we leave a message? Yes No

If an alternate person will be coordinating this referral after the assessment has been completed and forwarded, please provide the name and telephone number of that person:

Name: _____

Date: DD/MONTH/YYYY

Signature: _____



**Adult Addictions Inpatient Treatment
REFERRAL APPLICATION
(Part II)**



Name _____
 HCN _____
 Date of Birth _____

(To be completed by referring healthcare provider)

Name		Next of Kin	
Mailing Address		Relationship	
		Telephone Number	
Telephone Number		Email Address	
Alternate Number			
Email Address		Referral Source	
Date of Birth	DD/MONTH/YYYY	Agency	
Health Care Number		Telephone Number	
Gender		Email Address	
Language of Preference		Mailing Address:	
Are you of Aboriginal Origin?			

Does the client have an address to return to? Yes No
 If different than above please provide:

Will you the referral source be providing follow up care? Yes No

If no, please provide contact information for the health care provider providing follow up care (name, address, telephone number, fax number and email address)

1. Is this a referral for:

Substance Abuse Treatment Yes No Both Substance Abuse
 Problem Gambling Treatment Yes No and Problem Gambling Treatment Yes No

2. Reason for referral or admission to your program (presenting problems/concerns):

3. Previous Addictions Treatment:

Name: _____

Date: DD/MONTH/YYYY _____

Signature: _____



**Adult Addictions Inpatient Treatment
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(Part III)**



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4. Substance Abuse /Gambling History:

Substances of Choice	Method of use: oral/smoked/snorted/IV	Length of use	Amount consumed daily	Date of last use

Type of Gambling	Duration of problem gambling	Frequency	Last date of gambling	SOGS score

Does the client smoke? Yes No If yes: Frequency _____

Is the client willing to participate in a smoking cessation program? Yes No

5. History of Withdrawal Symptoms:

Has the client ever experienced severe symptoms such as seizures or hallucinations when he/she has stopped drinking or using in the past? Yes No If yes, please describe: _____

Is the client requiring withdrawal management support? Yes No

Are there withdrawal management services available to the client in his/her own community? Yes No

Is the client currently using benzodiazepines or barbiturates? Yes No

Is the client capable of his/her own self-care? Yes No

Does the client have diabetes? Yes No

Does the client have high blood pressure? Yes No

Does the client have heart problems? Yes No

Is there evidence of head injury? Yes No

Has the client ever experienced seizures? Yes No

Name: _____

Date: DD/MONTH/YYYY

Signature: _____



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6. Psychological/Mental Health:

Has the client ever been diagnosed with a mental health problem by a qualified mental health professional? [] Yes [] No

If yes, what was/is the diagnosis?

Has the client ever been hospitalized for a mental illness or a mental health problem? [] Yes [] No

If yes, when? _____

- Reason(s): Suicidal ideation [] Yes [] No [] Past [] Current
Suicide attempts [] Yes [] No Date of last attempt? DD/MONTH/YYYY
Self-harm (mutilation) [] Yes [] No
Depression [] Yes [] No
Mania [] Yes [] No
Anxiety [] Yes [] No
Phobias [] Yes [] No
Eating disorders [] Yes [] No
Hallucinations (auditory / visual) [] Yes [] No
Obsessive/compulsive behavior [] Yes [] No
Panic attacks [] Yes [] No
Nightmares/flashbacks [] Yes [] No
Homicidal Ideation [] Yes [] No
Fire Setting [] Yes [] No

Comments: _____

7. Marriage/Relationship (status, impact of substance use or gambling, partner's substance use or gambling behavior):

8. Family (family of origin, impact of alcohol/drug use or gambling on family members, history of substance use or gambling in family):

9. Social/Leisure (peer group, social life, impact of substance use or gambling):

Name: _____

Date: DD/MONTH/YYYY

Signature: _____



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10. Education level:

- College (completed)
University/College (partial)
Technical/Trade School
University (MA)
Secondary (completed)
Elementary (grade 8 or less)
University (MA, PHD)
Secondary (partial)
Unknown

11. Employment:

- Full-time
Retired
Student/Retraining
Disability Insurance
Family Support/ Inheritance
Part-time
Disability assistance
Unemployed seeking work
Guaranteed Income (pension)
Social Assistance
Employment Insurance
Homemaker
Unemployed not seeking work
Unknown Financial Status
Other (investment/student loan)

If the client is not working, when was he/she last employed?

Impact of substance use/gambling on education/employment:

12. Legal History:

- Past Criminal Charges: Yes No
History of Assault/Violence: Yes No
Current Legal Involvement: Yes No
(Charges, probation order, upcoming court) (See criteria for admission)
Are you coming for treatment because of a court order? Yes No

13. Group Therapy.

Is the client willing to participate in group therapy and a group environment? Yes No

Comments:

14. Specific Needs (learning disability, difficulty with reading and/or writing, hearing impairment, physical disability, intellectual or developmental disability, cognitive or memory problems, speech impairment, language barriers):

Name:

Date: DD/MONTH/YYYY

Signature:



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(Part VI)



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15. Clinician's Impressions: _____

_____	_____	DD/MONTH/YYYY
Printed Name of Client	Signature of Client	Date
_____	_____	DD/MONTH/YYYY
Printed Name of Referral Source	Signature of Referral Source	Date

Please return this form to:

Intake Coordinator
P.O. Box 2005
35 Boones Road
Corner Brook, NL
A2H 6J7
Telephone: (709) 634-4506, Fax: (709) 634-0160

Name: _____ Date: DD/MONTH/YYYY

Signature: _____

Eastern and Western Health acknowledges and respects the privacy of individuals. The personal information is being collected under the authority of sections 29, 30 and 31 of the Personal Health Information Act and will be used for processing your referral application. If you have any questions about the collection of this information, please contact Eastern Health, Regional Access & Privacy office (709) 777-8025. Western Health Regional Access & Privacy Office (709) 637-5000 ext. 5248



**Adult Addictions Inpatient Treatment
REFERRAL APPLICATION
(Part VIII)**



Name

HCN

Date of Birth

CLIENT AGREEMENTS

Please read and sign prior to attending the inpatient treatment centre you have been assigned to. If you have any questions about the agreements, feel free to ask your counsellor.

Client Expectations Agreement: I agree to live up to the following expectations of the inpatient treatment centre to the best of my ability:

- 1) I will not use alcohol or drugs (except medication prescribed by a doctor or nurse practitioner), or participate in gambling activities while I am in treatment. I understand that failure to do this may result in discharge from the treatment program.
- 2) I will work to the best of my ability to build a new lifestyle free from my addiction.
- 3) I will work within the structure of this program, as outlined, and attend the various activities (lectures, films, meetings) at the scheduled time. I understand that it is my responsibility to be present and on time for all scheduled activities. Failure to do this may result in discharge from the treatment program.
- 4) I will attend all meetings of Alcoholics Anonymous, Narcotics Anonymous, or other self-help groups that are part of the treatment program.
- 5) I agree that I have a responsibility to my group members and myself and that the situations that are described in group remain in group to protect the trust that group members have for one another.
- 6) ***I will not borrow money from other residents while involved in the treatment program. I will not lend money to other residents.***
- 7) I will complete all assignments and hand them in at the designated time.
- 8) I understand that any kind of violence will not be tolerated. Any threatening, abusive, or hostile behaviour to self or others, will result in immediate action. It could lead to discharge, criminal charges, and, where applicable, invoice for property damage.
- 9) I will not form an exclusive or sexual relationship with any person while I am involved in treatment. I understand that such behaviour will result in immediate discharge.
- 10) I understand that at any time, I may be asked by staff to submit to a random urine test for the purpose of an alcohol/drug screening. I understand that refusal to take such a test is grounds for discharge from treatment.
- 11) I understand that my personal belongings, including my vehicle, will be searched upon admission to, and discharge from, the Centre and may be searched at any point during the program. This is to ensure that the property remains free from addictive substances. I further understand that I will be informed of and present for any such searches. Refusal to consent to such searches will result in discharge.
- 12) I understand that regular nightly room checks will be conducted by staff during my stay. I agree to wear night attire when going to bed.



Adult Addictions Inpatient Treatment
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(Part IX)



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CLIENT AGREEMENTS (Con't)

- 13) I understand that I will not be permitted to smoke on the centre's property, in keeping with the organization's Smoke Free Policy.
 - 14) I understand that I will not be permitted to wear any scented products while at the Centre.
 - 15) I will dress appropriately at all times. I will not wear T-shirts that may be an indication of my addiction (i.e., beer shirts). I will not wear clothing with sexual comments, foul language etc., which may be offensive to others. I understand that proper footwear will be worn at all times.
 - 16) I understand that at any time, health care professionals may be observing the work being done with clients at the treatment centre. I understand that I will be informed in advance of the presence and identity of the observer and that this person will be bound by rules of confidentiality. This observation may include social/health care and addictions staff and students, sitting in on individual or group sessions or by using a one-way observation mirror and/or audio equipment. The purpose of this observation is to provide staff supervision and training, and to ensure we provide the best possible service to clients.
- I have read the above expectations, understand their meaning and agree to follow them.
- I understand that failure to follow these expectations and the rules and regulations that have been explained to me mean that I will be choosing to **discharge** myself from treatment.

Signature of Client

DD/MONTH/YYYY

Date