

# Application for Treatment

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## Round Lake Treatment Centre

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200 Emery Louis Road  
Armstrong, BC V0E 1B5  
Intake Phone: (250) 546-8848  
Intake Fax: (250) 546-3087  
[www.roundlake.bc.ca](http://www.roundlake.bc.ca)  
[intake@roundlake.bc.ca](mailto:intake@roundlake.bc.ca)



NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

### RLTC APPLICATION FOR TREATMENT

(To Be Completed by the A&D Referral Worker)

Surname (legal): \_\_\_\_\_ First Name(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Email: \_\_\_\_\_

Birth date: Year \_\_\_\_ Month \_\_\_\_ Day \_\_\_\_ Gender: Male \_\_\_\_ Female \_\_\_\_  
(Area Code)

Aboriginal Ancestry  YES  NO Band Member  YES  NO Aboriginal Information \_\_\_\_\_ On Reserve  YES  NO  
(Band Name, Inuit, Métis, Aboriginal Community)

Status Number 

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S.I.N. 

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 Care Card Number 

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How are medical insurance premiums paid? D.I.A.  M.H.R.  Self

How is the treatment paid? FNIHB  M.H.R.  A.D.S.P.  Self  Band

How will client travel be paid TO and FROM treatment? Self  Band  Other

Emergency Contact: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
(Area Code)

Emergency contract email: \_\_\_\_\_

Emergency Contacts Relationship to Client: \_\_\_\_\_

### REFERRAL ASSESSMENT

1. Has the client attended RLTC before?  YES  NO  
If "YES," did the client complete?  YES Date: \_\_\_\_\_  NO  N/A  
If "NO," please explain reason for client's non completion \_\_\_\_\_

2. Is the client applying to do a Refresher?  YES  NO  
If "YES," the client must have maintained complete abstinence since his/her attendance at treatment.

What are the client's immediate goals for refresher program: \_\_\_\_\_

4. The client is committed to complete an intensive, structured treatment process?  YES  NO

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5. Does the client express a desire (willingness) for him/her self to change?  YES  NO
6. Is the client willing to be involved in all types of intensive counseling activities?  YES  NO
7. Does the client express a need to change his/her life situation?  YES  NO
8. Does the client believe addictions are a problem to his/her well being?  YES  NO
9. Does the client believe sobriety is needed in order to change?  YES  NO
10. Is the client able and willing to adhere to rules and guidelines of RLTC  YES  NO
- If "YES," has the client read and understand RLTC guidelines?  YES Date: \_\_\_\_\_  NO

11. Any major problems in client's life situation relating to alcohol/drug abuse in the following areas?

- |                 |  |                |  |
|-----------------|--|----------------|--|
| Physical Health | <input type="checkbox"/> YES <input type="checkbox"/> NO | Legal          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Housing         | <input type="checkbox"/> YES <input type="checkbox"/> NO | Family/Friends | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Employment      | <input type="checkbox"/> YES <input type="checkbox"/> NO | Leisure Time   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Financial       | <input type="checkbox"/> YES <input type="checkbox"/> NO | Mental Health  | <input type="checkbox"/> YES <input type="checkbox"/> NO |

If you have answered "yes" to any of the above, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. The client **must be free** of all factors that would interfere with the RLTC treatment program? (Family, work, school, medical, legal, childcare, court appearance etc)  YES  NO

13. Does the client have discharge plans:

- for basic needs (housing, food, etc.)  YES  NO
- for continued AA or NA or other support group attendance.  YES  NO
- to continue in cultural/spiritual activities at local community.  YES  NO
- for Outpatient / Aftercare counseling with you as A/D counsellor.  YES  NO

14. Does the client have specific needs to be addressed in treatment?  YES  NO

If "yes" please explain:

- Spiritual \_\_\_\_\_
- Mental \_\_\_\_\_
- Emotional \_\_\_\_\_
- Physical \_\_\_\_\_

## PHYSICAL HISTORY

1. Does the client have any physical limitations that would prevent them from doing:

Daily living chores, recreational or cultural activities?  YES  NO

2. Does client require a wheel chair accessible room/bathroom?  YES  NO

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3. Does the client have any special needs RLTC staff needs to be aware of while client is in treatment?  YES  NO

4. If you have answered "yes" to any of the above three questions, please explain \_\_\_\_\_

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**CURRENT MARITAL and FAMILY STATUS**

Single  Common-Law  Divorced  Married  Separated  Widowed

Extended Family  Living Alone  Single Parent

Living with friends  Living with family  Living with Spouse & Children

Number of dependent (0 – 18 years of age) children: \_\_\_\_\_

Ages of children  0 to 4  5 to 9  10 to 13  14 to 18

1. Does client have secure Child Care for the six week treatment program?  YES  NO

2. Has client been mandated to treatment by MCF?  YES  NO

If "yes" client understands RLTC is not obligated to keep them if not willing to adhere to rules and guidelines of program and willing to partake fully in program  YES  NO

3. Is a Social Worker currently involved with the Family?  YES  NO

If "yes" please provide details of involvement. \_\_\_\_\_

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**SPOUSAL SUPPORT PROGRAM:**

Will the spouse attend:  3 week spousal support program? (Must complete a full application)

Complete treatment program? or  N/A

If spouse is attending full treatment See and complete Couples program section on page 8

If spouse is attending 3 week treatment, please provide spouses name: \_\_\_\_\_

**\*\*NOTE: IF THE SPOUSE HAS LESS THAN 6 MONTHS ABSTINENCE FROM A&D'S THEY ARE RECOMMENDED TO ATTEND A COMPLETE TREATMENT PROGRAM AND MUST COMPLETE A SEPARATE APPLICATION FOR TREATMENT.**

1. Does the spouse have an alcohol/drug misuse problem?  YES  NO  N/A

2. Does the spouse receive outpatient A&D counseling?  YES  NO  N/A

3. Does the spouse attend any Support groups (Al anon etc)  YES  NO  N/A

4. Are children involved and childcare issues are not a concern?  YES  NO  N/A



NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

### EMPLOYMENT STATUS

Occupation: \_\_\_\_\_

Full Time  Part Time  Full Time Seasonal  Part Time Seasonal

Unemployed  Retired  Student  Homemaker

Not in Labor Force (due to disability)

Source of Income? \_\_\_\_\_

**\*\*NOTE:** IF CLIENT HAS NO SOURCE OF INCOME OR SECURE HOUSING PRIOR TO TREATMENT, ARRANGEMENTS TO APPLY FOR SOCIAL ASSISTANCE SHOULD BE MADE PRIOR TO TREATMENT, AS APPOINTMENTS ARE DIFFICULT TO SET UP WHILE CLIENT IS HERE.

### PRIOR TREATMENT AND/OR COUNSELLING

List all previous treatment centre's attended and/or counseling received for Alcohol &/or Drugs, Emotional Problems (anger, depression, Suicide), Family Problems (marriage/relationship), Process Addictions (gambling, shopping), Legal.

Treatment Centre/ Counselor/Institution Name	Location	Date (M/D/Yr) Start to End	Issues Worked On	Completed <input type="checkbox"/> YES <input type="checkbox"/> NO
1.				<input type="checkbox"/> YES <input type="checkbox"/> NO
2.				<input type="checkbox"/> YES <input type="checkbox"/> NO
3.				<input type="checkbox"/> YES <input type="checkbox"/> NO
4.				<input type="checkbox"/> YES <input type="checkbox"/> NO
5.				<input type="checkbox"/> YES <input type="checkbox"/> NO

### EDUCATIONAL STATUS

1. Check highest level of education completed:

Elementary (Kindergarten, Grades 1 – 12)

Graduated High School (High School Diploma)

Trade School (ex. Hairdressing, Carpentry, Welding)

College (Post Secondary, Diploma)

University (Bachelor, Masters)

Graduate Degree (PhD, Doctorate)

2. Has client attended Residential School?  YES  NO

If, "yes", for how long? \_\_\_\_\_

And how does the client describe their residential school experience? \_\_\_\_\_

3. Does client have difficulty with reading?  YES  NO

4. Does client have difficulty with writing?  YES  NO

5. Does the client have any learning problems/disabilities?  YES  NO

6. Will the client require assistance with reading/writing?  YES  NO

**\*\*NOTE:** RLTC HAS THE AA/NA BIG BOOK & 12X12 ON AUDIO TAPE FOR CLIENTS WHO HAVE LITERACY DIFFICULTIES.

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

7. Your client agrees to complete AA steps 1 to 3 while in treatment?  YES  NO
8. Your client agrees to complete a guided daily journal while in treatment?  YES  NO

### CURRENT DIAGNOSTIC STATUS

The client ever been professionally assessed by a psychologist or psychiatrist?  YES  NO

If "yes", please provide dates and details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Check all applicable boxes:**

Provide Brief explanation if applicable:

Trauma (PTSD) \_\_\_\_\_

Depression \_\_\_\_\_

Anxiety/Panic Disorder \_\_\_\_\_

Any type of mental disorder \_\_\_\_\_

Brain Injury \_\_\_\_\_

ADD/ADHD \_\_\_\_\_

Anger/Acting Out \_\_\_\_\_

Family Trauma \_\_\_\_\_

(Child apprehension, custody problems, lateral violence, marriage problems/breakdown, etc)

Grief and/or Loss \_\_\_\_\_

(please explain type of loss with who what, when)

FAS/FAE \_\_\_\_\_

(If FAS/FAE please provide results along with the date of testing)

Suicide Ideation

Suicide Attempts

(Provide details: date of suicide attempt(s), specify whether client was hospitalized, including length of hospitalization, how the attempt was made, etc., if attempt was within the past year – indicate if client is stable?) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is Suicide a concern?  YES  NO

If "yes", what is the level of risk? \_\_\_\_\_

**\*\*NOTE: PLEASE INCLUDE COPY OF HOSPITAL DISCHARGE SUMMARY REPORT WITH THE APPLICATION FOR TREATMENT FOR ANY SUICIDE ATTEMPTS WITHIN THE PAST YEAR.**

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

## COUPLES PROGRAM

**\*\* Only to be completed** by clients requesting to be admitted as a Couple and see admissions criteria posted

1. Have you seen the couple a minimum of 4 sessions?  YES  NO
2. Are the couple committed to complete a full couples program?  YES  NO
3. Have the couple attended any Support groups (Al anon etc) together?  YES  NO
4. Are children involved and childcare issues are not a concern?  YES  NO  NA
5. Was there any significant incidents or events that lead to the decision to apply for couple's treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What does the Couple identify as the main reason for coming in for Couple treatment?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. How has the Couple been prepared for coming into treatment?

- |                      |                              |                             |                        |                              |                             |
|----------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Read RLTC guidelines | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Arranged for childcare | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sought counseling    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | attended support group | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
- 
- \_\_\_\_\_
- 
- \_\_\_\_\_

8. Have long has the Couple been in cohabiting or in the relationship?

- 1 to 4 years  5 to 9 years  10 to 15 years  20 years plus

9. In the event, that one of the partnership leaves treatment either via dismissal or own choice, is the other willing to commit to finish his/her alcohol & drug treatment?  YES  NO

10. Describe the role and use of addictions in the relationship?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. What have you discussed with the couple regarding aftercare plans and coming back into the community and home? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Does the couple have a post-treatment appointment set?  YES  NO

If "YES," state time and date of appointment. Date: \_\_\_\_\_

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

### CLIENT SNAP (Strength, Needs, Abilities, Preferences)

(This is to be answered from the client's perspective)

What does the client believe are his/her?

- Strengths (assets, resources): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- Needs (liabilities, weaknesses): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- Abilities (skills, aptitudes, capabilities, talents, competencies): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- Preferences (those things the client thinks, feel will enhance his/her treatment experience): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- In the client's own words what are their presenting problems & challenges? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### REFERRAL WORKERS/COUNSELOR'S ASSESSMENT

(This section must be completed by the A&D Referral Worker)

1. Is the client receiving counseling from you?  YES  NO

If "yes", how many pre-treatment counseling sessions has the client attended in the last 3 months? \_\_\_\_\_

**\*\*NOTE:** CLIENT MUST HAVE A MINIMUM OF SIX ONE HOUR (OR LONGER) PRE-TREATMENT COUNSELING SESSIONS WITH AN A&D COUNSELOR OR REFERRAL WORKER.

2. How was the client referred to you? \_\_\_\_\_

3. Is the client receiving other counseling services?  YES  NO

If "yes", list the other counseling agencies. \_\_\_\_\_

**\*\*NOTE: IF YOU ANSWERED YES** to question three, all counselors and you as the A&D referral worker working with the client are REQUIRED to complete and submit this portion of application package.

4. What issues has the client worked on in his/her sessions and what is your perception of the client's readiness for treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. What do you believe is Round Lake Treatment Centre's role in the clients' overall treatment plan and their motivation for coming to treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

**ALCOHOL SCREENING TEST**

#	The following questions are about your alcohol use during the past 12 months	Circle Your Response	
		YES	NO
1.	Do you feel that you are a normal drinker?	YES (0)	NO (2)
2.	Do friends or relatives think you are a normal drinker?	YES (0)	NO (2)
3.	Have you attended a meeting of Alcoholics Anonymous (AA)?	YES (5)	NO (0)
4.	Have you lost friends or girlfriends/boyfriends because of your drinking?	YES (2)	NO (0)
5.	Have you gotten into trouble at work because of your drinking?	YES (2)	NO (0)
6.	Have you neglected your obligations, your family or your work for two or more days in a row because you were drinking?	YES (2)	NO (0)
7.	Have you had delirium tremens (DT's), severe shaking, heard voices or seen things that were not there after heavy drinking?	YES (2)	NO (0)
8.	Have you gone to anyone for help about your drinking?	YES (5)	NO (0)
9.	Have you been in a hospital because of drinking?	YES (5)	NO (0)
10.	Have you received a 24-hour roadside suspension or have you been charged for impaired driving?	YES (2)	NO (0)
<b>Total Score</b>			

**Total scores may range from 0 to 29.** Scores of 6 or greater are considered to reflect serious problems with alcohol.

**DRUG SCREENING TEST**

#	The following questions concern information about your potential involvement with drugs <u>not including alcoholic beverages</u> during the past 12 months	Circle Your Response	
		YES	NO
1.	Have you used drugs other than those required for medical reasons?	YES (1)	NO (0)
2.	Have you abused prescription drugs?	YES (1)	NO (0)
3.	Do you abuse more than one drug at a time?	YES (1)	NO (0)
4.	Can you get through the week without using drugs?	YES (0)	NO (1)
5.	Are you always able to stop using drugs when you want to?	YES (0)	NO (1)
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	YES (1)	NO (0)
7.	Do you ever feel bad or guilty about your drug use?	YES	NO

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

		(1)	(0)
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	YES (1)	NO (0)
9.	Has drug abuse created problems between you and your spouse or your parents?	YES (1)	NO (0)
10.	Have you lost friends because of your use of drugs?	YES (1)	NO (0)
11.	Have you neglected your family because of your use of drugs?	YES (1)	NO (0)
12.	Have you been in trouble at work because of drug abuse?	YES (1)	NO (0)
13.	Have you lost a job because of drug use?	YES (1)	NO (0)
14.	Have you gotten into fights when under the influence of drugs?	YES (1)	NO (0)
15.	Have you engaged in illegal activities in order to obtain drugs?	YES (1)	NO (0)
16.	Have you been arrested for possession of illegal drugs?	YES (1)	NO (0)
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES (1)	NO (0)
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc)?	YES (1)	NO (0)
19.	Have you gone to anyone for help for drug problem?	YES (1)	NO (0)
20.	Have you been involved in a treatment program specifically related to drug use?	YES (1)	NO (0)
	<b>Total Score</b>		

Drug Misuse Screening Test Score	Problem Severity
0	No Problem
1 – 5	Low level of problems related to drug abuse
6 – 10	Moderate level of problems related to drug abuse
11 – 15	Substantial level of problems related to drug abuse
16 – 20	Severe level of problems related to drug abuse

How receptive was the client in completing these screening assessments? \_\_\_\_\_

\_\_\_\_\_

What is your pre-treatment assessment of client's use of Alcohol and/ or drugs? \_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

**ALCOHOL / DRUG HISTORY**

Alcohol and/or drug misuse is considered to be misuse if you have tried any of the following more than two times in order for the mood-altering effect. Please put a circle around the primary drug(s) of choice i.e. primary drug of choice is the one that is causing you the most difficulty in your life.

TYPE	Age of first use	Frequency/How often used: Daily/wkly/mthly	Amount/Quantity	Method of Use Inject/smoke/injest/snort	Date of last use M/D/Y
<b>**NOTE: Put a circle around primary drug(s) of choice</b>					
Alcohol (eg. beer, wine, hard liquor)					
Cannabis (e.g. pot, hash)					
Cocaine (e.g. crack, coke)					
Hallucinogen (e.g. acid, mushrooms, PCP, ketamine)					
Barbiturate (e.g. phennies, yellow jackets)					
Amphetamine (crystal meth, ecstasy, speed)					
Heroin (eg. china white, crank)					
Opiate (eg. morphine, codeine, opium)					
Inhalant (e.g. glue, hairspray)					
Illicit Methadone					
Benzodiazepine (eg. sleeping pills, tranquilizers)					
Over the Counter Drugs (e.g. cough syrup)					
Other Prescription Drugs (e.g. T3's, Valium)					
Tobacco					
Other					

**\*\*IMPORTANT NOTE: ADMISSION CRITERIA – CLIENT MUST HAVE 2 WEEKS (14 FULL DAYS) CLEAN FROM ALCOHOL & DRUGS PRIOR TO ADMISSION TO TREATMENT > NO EXCEPTIONS.** Clients may be drug tested upon admissions. If tested positive will be declined acceptance into the program.  
**CRYSTAL METH USE CLEAN TIME IS 5 MONTHS ABSTINENCE FROM CRYSTAL METH. NO EXCEPTIONS.**

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

### ADMISSION CRITERIA FOR CLIENTS WITH LEGAL ORDERS ATTENDING RLTC

- RLTC limits the number of clients per intake with current legal orders in place.
- The applicant must be released on the merit of completing their incarceration. RLTC does not participate in mandated treatment as a condition for eligibility of release from probation or parole. Round Lake is not under any obligation to accept a person who has been legally ordered to attend treatment.
- The client must not have any upcoming legal issues/court cases, **ALL** court dates must be dealt with prior to admission to RLTC. Court date interference with treatment may result in dismissal from program until resolved.
- Applicants coming from an institution must reside in a halfway house, recovery house, John Howard House Society, or the community for a minimum of one month before entering RLTC.
- The client is expected to cooperatively participate and follow our treatment and program guidelines, with the understanding that RLTC is under no obligation to keep a client who does not participate or comply with treatment direction.
- RLTC does not accept charged or convicted sexual offenders.
- RLTC does not accept client's with the following legal conditions: a) Electronic monitoring, b) Temporary Absence, c) 24 Hour Supervision, d) Day Parole, e) All other legal conditions are reviewed on a case by case basis.

### LEGAL STATUS:

A. Current Legal Status is NOT APPLICABLE

B. Does the client have any current legal orders in place?  YES  NO

C. If "yes" to B, you must specify type of legal order in place (I.e. Spousal Assault, DWI, Theft, Breach, Failure to Appear, Undertaking, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

D. Were the charges Alcohol/Drug related?  YES  NO

E. Is the client restricted from going on day or weekend passes?  YES  NO

Name of Probation Officer: \_\_\_\_\_ Telephone No: \_\_\_\_\_

**\*\*IMPORTANT NOTE:** A COPY OF THE PROBATION ORDER MUST BE INCLUDED WITH THE APPLICATION FOR TREATMENT BEFORE THE APPLICATION CAN BE ASSESSED.

F. Does the client have any Pending Charges/Court Dates?  YES  NO

G. Does the client have any previous Convictions/Charges?  YES  NO

H. If you answered "yes" to G. please list all previous convictions/charges and dates \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

### CONSENT TO ATTEND and PARTICIPATE IN TREATMENT

I, (Client's Name, PLEASE PRINT) \_\_\_\_\_, consent to attend and participate at RLTC and I have reviewed the following points with my A&D Referral Worker and **initialed** as confirmation of my understanding of the following points:

1. \_\_\_\_\_ I understand that if I do not have 2 weeks (14 full days) from ALCOHOL & drugs, I will be immediately discharged from the program.
2. \_\_\_\_\_ I understand an incomplete application and lack of supporting documentation delays in the processing of my application and confirmation of an intake date.
3. \_\_\_\_\_ I consent to the Intake Coordinator contacting referral agencies, such as Probation Officers, Medical Practitioner's, etc. to obtain clarification on information included in this application for treatment. If on provincial assistance, I agree the Intake Coordinator can release confirmation of my intake and discharge dates to my Employment and Assistance Worker.
4. \_\_\_\_\_ I understand if I have legal issues, a copy of the probation order must be submitted with my application for treatment; and **ALL** pending court dates must be dealt with prior to admission to RLTC. I understand any court date interference may result in my being dismissed until resolved.
5. \_\_\_\_\_ I understand the Intake Coordinator will notify my referral worker by letter to confirm my acceptance to treatment.
6. \_\_\_\_\_ While in treatment, I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.
7. \_\_\_\_\_ I understand the importance of being free from and have taken care of all outside business, which will take my attention away from the treatment program.
8. \_\_\_\_\_ I understand if I am discharged or voluntarily leave treatment that Social Assistance and First Nations Inuit Health Branch will not cover my return travel and that I am responsible for return travel. I will be arriving at treatment with my return travel arrangements in place.
9. \_\_\_\_\_ I have reviewed and completed this application for treatment with my referral worker, answering all questions and providing all information truthfully and thoroughly to the best of my ability.

### CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

10. I, (Please Print Name) \_\_\_\_\_ hereby give permission for RLTC staff to contact the referral worker(s) listed below for the release of information in regard to pre-treatment conference call, progress during treatment, Aftercare planning, and Final Discharge Report.

REFERRAL WORKERS NAME \_\_\_\_\_

TITLE \_\_\_\_\_ REFERRAL WORKER 4 LETTER CODE \_\_\_\_\_

ORGANIZATION / AGENCY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

POSTAL CODE \_\_\_\_\_ TELEPHONE # \_\_\_\_\_ FAX \_\_\_\_\_

EMAIL \_\_\_\_\_ ALTERNATE CONTACT PERSON \_\_\_\_\_

\_\_\_\_\_  
(Client's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Referral Worker's Signature)

\_\_\_\_\_  
(Date)

\*\* The alternate contact person is for confirmation or admission processing only – the alternate contact will not be included in the release of confidential information prior to, during or after treatment). The client may change or revoke this release at anytime by giving notice to Round Lake Treatment Centre in writing. It is up to the client to inform their referral worker of the change. **\*\*NOTE: THIS FORM IS APPLICABLE FOR ONE YEAR AFTER THE DATE SIGNED UNLESS REVOKED.**

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

## **FAXING CLIENT CONFIDENTIAL INFORMATION WAIVER**

1. I, \_\_\_\_\_ have been spoken to and advised by Round Lake Treatment Centre, that I am responsible for the request to have the Client Confirmation Of Intake letter faxed to my place of business for :  
(Client name) \_\_\_\_\_ DOB: \_\_\_\_\_
2. I am responsible for this choice and decision and will not hold Round Lake Treatment Centre accountable for the outcome of my decision.
3. I am responsible to inform my client of the decision to have the Client Confirmation of Intake letter faxed with the understanding that the place or time the letter is being faxed may not secure confidentiality.
4. I understand that no client information will be faxed to me unless this form is completed and received by the Intake Coordinator at Round Lake Treatment Centre.
5. I, \_\_\_\_\_ hereby release Round Lake Treatment Centre and its directors, officers and employees from all liability whatsoever for any and all consequences that may arise from this signed request.

**READ AND SIGNED BY ME THIS** \_\_\_\_\_ day of \_\_\_\_\_ 2010.

\_\_\_\_\_  
(Referral Worker's signature)

\_\_\_\_\_  
(Client name)

\_\_\_\_\_  
(Work Title & Agency Name)

\_\_\_\_\_  
(Client signature)

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

## TRAVEL FORM

This form is to be filled out by **the person responsible for the return travel costs for the client**. Round Lake Treatment Centre is a non-profit organization and is unable to pay for travel costs.

I, \_\_\_\_\_ (print name) agree to pay for any and all travel costs incurred by \_\_\_\_\_ (client's name). I understand that if the client is discharged or voluntarily leaves treatment that Social Assistance and First Nations Inuit Health Branch will not cover return travel.

In the case that Round Lake Treatment Centre must pay for any of the client's travel, I agree to reimburse Round Lake Treatment Centre for all costs incurred. I understand that I will be sent an invoice which will state clearly all cost incurred by RLTC to get the above named client safely home.

**Please note:** any outstanding debts incurred by above noted client will prevent future intake process until it is paid in full

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email address: \_\_\_\_\_

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

**ROUND LAKE TREATMENT CENTRE PRE-ADMISSION MEDICAL**  
Please print legibly.

Patient's Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Care Card Number 

--	--	--	--	--	--	--	--	--	--

Status Number 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Informed Consent Must Be Completed with Patient:**  
I, (client's name) \_\_\_\_\_ hereby request and give permission to Dr. \_\_\_\_\_ to release my medical information to Round Lake Treatment Centre and my A&D Referral Worker. I also consent to have RLTC RN or Counsellor consult or inquire with my above named physician on any of my medical needs while in treatment.  
  
Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**FUNCTIONAL INQUIRY AND PHYSICAL EXAM:**

ALLERGIES  YES  NO If "yes" please specify \_\_\_\_\_

**\*\*NOTE: PATIENT MUST HAVE EPI-PEN OR ANAKIT IF ALLERGIC TO BEES or NUTS.**

DIABETES  YES  NO

BP: \_\_\_\_\_

EENT Hearing Loss \_\_\_\_\_ Impaired vision \_\_\_\_\_

RESP Asthma \_\_\_\_\_ S.O.B. \_\_\_\_\_ Chronic Cough \_\_\_\_\_

CVS CHF \_\_\_\_\_ Angina \_\_\_\_\_ Murmur \_\_\_\_\_

GI Ulcers \_\_\_\_\_ Reflux \_\_\_\_\_ Dyspepsia \_\_\_\_\_ Liver \_\_\_\_\_

GU Freq UTI \_\_\_\_\_ Prostatism \_\_\_\_\_ Neuro \_\_\_\_\_

Menstrual LMP \_\_\_\_\_ Pregnant?  YES  NO

If "yes" what trimester \_\_\_\_\_ Any prior problematic or difficult pregnancies \_\_\_\_\_

**\*\*NOTE:** For PREGNANT CLIENTS will be asked to sign a waiver form due to rural location of centre and will only accept pregnant clients that have had NO prior problematic or difficult pregnancy history.

LOCOM \_\_\_\_\_

SKIN Infestations \_\_\_\_\_ Infections \_\_\_\_\_

STD's NEG POS Type \_\_\_\_\_

Hep C NEG POS

HIV/AIDS testing  YES  NO Results: NEG POS

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

**IS THIS PATIENT ON ANY MEDICATIONS?**  YES  NO

Please Print Name of Medication(s):

Relate what the medication is for?

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

Are you aware of current or recent medical problems which may or may not require follow-up while patient is in a residential Alcohol & drug treatment facility?  YES  NO

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is Patient DUAL DIAGNOSIS?  YES  NO

If client is Dual Diagnosis list medications, type of illness, date of diagnosis, medication types & amounts, length of time on medication (if dose has increased/decreased since first diagnosed), brief descriptive of how person behaves when stable.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AS A PRE-REQUISITE TO A/D RESIDENTIAL TREATMENT THE PATIENT MUST:**

1. Be free from all communicable diseases (I.e. Scabies, Lice).
2. Have a T.B. Test in the last 12 months. POS NEG Date \_\_\_\_\_

**\*\*NOTE: IF TB SKIN TEST IS POSITIVE AND RESULTS MEASURE LARGER THAN 10MM, SKIN TEST RESULTS MUST BE FOLLOWED UP BY TB CHEST X-RAY.**

3. Have Two (2) weeks clean from ALCOHOL & mood-altering drugs prior to admission to Round Lake Treatment Centre.

**M.D. Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

OFFICE STAMP
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Dr's Signature \_\_\_\_\_

Date \_\_\_\_\_

Please ensure you have read and review the attached **SAFE/UNSAFE MEDICATIONS list** as non compliance with said list will result in the client not being accepted into Alcohol / Drug treatment.

**Round Lake Treatment Centre: SAFE/UNSAFE MEDICATIONS LIST**

The following list is for common and prescription medications, which are considered SAFE/UNSAFE for individuals in residential treatment and in recovery from A/D.

SAFE	UNSAFE
<p><b>PAIN MEDICATIONS:</b>            *PLAIN OR EXTRA STRENGTH TYLENOL OR THE EQUIVALENT.            *ASA OR ASPIRIN            *ADVIL OR IBUPROFEN            *TORADOL (<b>BY PRESCRIPTION ONLY</b>)            *POSSIBLE OTHER PRESCRIPTION MEDS.</p> <p><b>MAY BE SAFE:</b>  <b>LIMITED/AVAILABLE ONLY BY PRESCRIPTION:</b>            *TRYPTAN FOR SLEEP AND NERVES            *BUSPAR FOR NERVES            *IMMOVANE</p> <p><b>ANTIDEPRESSANTS SAFE WITH PROPER USE AND BY PRESCRIPTION ONLY:</b>            *ELAVIL (AMYTRIPTALINE)            *MOREX            *SERAZONE            *DESIPRAMINE            *ZOLOFT (SERTRALINE)            *PROZAC (FLUOXITINE)            *LUVOX (FLUOXAMINE)            *PAXIL (PAROXETINE)            *TRAZODONE (DESYREL)            *EFEXOR            *CELEXA            *SEROQUEL</p> <p><b>MIGRAINES:</b>            *IMITREX</p> <p><b>NON-SEDATING ANTIHISTAMINES:</b>            *SELDANE            *CLARITIN</p>	<p><b>AVOID PAIN MEDICATIONS THAT CONTAIN OPIATES (EG: CODEINE, METHADONE):</b>            * TYLENOL 1, 2, 3 OR 4    *TALWIN            * DEMEROL                    *PERCODAN            * PERCOCET                    *LERITINE            * FIORINAL PLAIN, ¼ OR ½            *LEVODROMARAM            *DILAUDID            *222, 282, 292, 692, DARVON (PROPOXYPHENE)</p> <p><b>AVOID NERVE &amp; SLEEPING PILLS INCLUDING:</b>            *VALIUM                        *LIBRIUM            *TRANXENE                    *SERAX            *ATIVAN                        *XANAX            *CLOMAZAPAM            *OTHERS USED FOR ANXIETY/NERVOUSNESS/TRANQUILIZER.</p> <p><b>AVOID SLEEPING PILLS INCLUDING THESE &amp; OTHERS:</b>            *DALMANE HALCION        *RESTORIL            *TUINAL                        *SECONAL</p> <p><b>AVOID MUSCLE RELAXANTS:</b>            *ROBAXISIL                  *ROBAXACET            *PARAFON                      *FLEXERIL</p> <p><b>OVER THE COUNTER MEDICATIONS CAN BE A SERIOUS THREAT:</b>            COUGH SYRUPS CONTAIN ALCOHOL, CODEINE AND ANTIHISTAMINES. THESE ARE ALL DRUGS, WHICH NEED TO BE AVOIDED.</p> <p><b>AVOID SEDATING ANTIHISTAMINES SUCH AS:</b>            *GRAVOL                        *ACTIFED            *DIMETAP                      *CHLORTRIPLON</p>

If a medication changes the way you feel, AVOID IT! This list is only a partial list; if you require more information please ask your doctor or pharmacist about non-mood altering medications. Be sure to check with you doctor to make sure generic medications fall into the SAFE category of acceptable meds.

**\*\*IMPORTANT NOTE:** CLIENT MUST HAVE TWO WEEKS ABSTINENCE FROM ALCOHOL & DRUGS PRIOR TO ADMISSION TO TREATMENT. UNSAFE/MOOD-ALTERING MEDICATIONS BROUGHT INTO TREATMENT AND TAKEN WITHIN TWO WEEKS PRIOR TO THE INTAKE DATE WILL RESULT IN CLIENT'S IMMEDIATE DISCHARGE FROM PROGRAM. ABSTINENCE FROM CRYSTAL METH IS 5 MONTHS minimum, preference is longer.