



Wanaki Center
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RELAPSE PREVENTION WEEK

Application form for the Wanaki Center

Application Procedures

Revised Nov. 2015

To fill out the form, you can print and fill it out in writing. Remember that the form must be signed by all parties concerned.

Wanaki's application package contains two (2) sections:

Section 1: What you should know before you apply and In-house responsibilities

Section 2: Client Section

STEP 1: Wanaki must receive the completed application before we can proceed with our clinical assessment.

STEP 2: Once Wanaki has received all sections of the application, which includes a quick telephone call with the applicant. The Center will complete their clinical assessment within 7 working days. The Center's decision to accept or refuse the client application will be provided in writing within this time period.

STEP 3: Once a client application has been assessed as admissible for treatment services, the client or referral will be faxed our application for admission decision form. Upon receipt of this document, the form must be faxed back to Wanaki within 7 days with the client and referral worker's signature confirming this date as acceptable for the client's treatment cycle intake and completion date.

STEP 4: Once Wanaki has received the signed admission decision form as accepted by the client and referral worker, the community is then responsible to arrange the travel and inform the Wanaki Center before the start of the treatment cycle.

Any changes in your client's treatment request or admission must be provided to the center in writing by fax as soon as possible, such as legal, medical or family situation.

Please ensure that all sections are signed and dated as Wanaki Center will not process an application that is not signed and/or dated by all significant parties.

The cycle intakes are done on **Sunday and we ask that clients be in before 2:00pm.**

Please ensure that the application is legible.

What do I need to know about the Wanaki?

- There are 4 cardinal rules:
 - No use of alcohol or drugs during the treatment
 - No violence of any kind
 - No intimate contact
 - No smoking in the building
- If you are accepted for treatment you must ensure that your personal and financial needs are met prior to entering the treatment center (i.e. banking issues, welfare, etc.). There will be a designated time for you to call your financial institutions to check bank balances. The Wanaki Center will not endorse any cheque on behalf of the resident.
- When you enter the Wanaki Center for treatment, you will have your personal belongings thoroughly searched upon entrance. All products and/or medications which contain alcohol and/or mood altering substances will be withheld by Wanaki. All prescribed medications will be held and allocated to the resident by a Counsellor or Program Facilitator. If any illegal drugs are found, your treatment will be terminated.
- All prepaid travel arrangements purchased by the community and/or government must be handed over to the Centre upon entrance.
- No overnights outside Wanaki unless exceptional circumstances arise.

- You are permitted to take medication including over-the-counter or non-prescribed medication (including vitamins) but it must be prescribed by your physician/doctor. Medication that may alter the behaviour of the resident's capacity to function within treatment must be evaluated by the treatment team.
- There will be no access to the telephones during your stay unless there is an emergency.
- You are required to bring the following items;
 - ✓ Valid medical card
 - ✓ Toothpaste and toothbrush
 - ✓ Hairbrush or comb
 - ✓ Shaving gear, shampoo, deodorant, Q-tips (no products with alcohol)
 - ✓ Sleep wear
 - ✓ Contact lens and contact solution (if applicable)
 - ✓ Feminine products (if applicable)
 - ✓ Clothing to adapt to the season he/she is entering
 - ✓ Sufficient cash/Interact card/Credit card
 - ✓ Prescription medication (for 1 week, if applicable)
 - ✓ In house footwear (ex. shoes, slippers)
 - ✓ Personal identification cards (Minimum 2)

Optional articles that you can bring:

- ✓ A traditional skirts for ceremonies (women)
 - ✓ A ribbon shirt (men)
 - ✓ Hand drum or musical instrument (optional)
- The Algonquin medicines will be supplied at the Wanaki (sage, tobacco, sweet grass and cedar), so no need for you to bring your own.

I _____ have reviewed these conditions to admission and understand that if certain conditions are not respected, this will result in an infraction report or my termination from the center.

Client Signature

Date

Referral Signature

Date

Responsibilities of people coming to seek healing

Daily Living Responsibility

To ensure that everyone takes their responsibilities seriously, we will be tracking when a person shows a lack of respect of their responsibilities. This information will be shared with the staff and the resident involved. At that moment, a discussion will be had to re-examine the motivation of the resident to engage in treatment in order to improve their life.

- I will be given a wake-up call by the Program Facilitator on duty once every morning, Monday to Friday at 7:00am and on weekends at 8:00am. If I have kitchen duty I will be provided a wakeup call a half hour earlier since I will be required to shower before reporting to kitchen duty. I must be out of my bedroom by 7:30am during the week and 8:30 on the weekend.
- A typical day at the Wanaki will be as follows:
 - Breakfast from 7:30am to 8:15am (weekends from 8:30am to 9:15am)
 - Distribution of medicine where applicable (hours are posted in your room)
 - Program begins at 8:30 with the opening of the circle which includes smudging
 - A walk will be done before the start of the workshops
 - Lunch from 12pm to 12:45pm
 - Program begins at 1pm
 - Closing circle
 - Personal time
 - Supper from 5pm to 5:45pm
 - Evening activity
 - Personal time
 - Bed time (lights out at 11pm)
- I am required to keep my personal room clean and tidy (i.e. making my bed each day).
- I'm responsible to work to my best ability on my 4 aspects:
 - Physical (walking, exercise DVD, using the gym, going up and down the stairs)
 - Mental (paying attention during the workshops, reading, learning from others)
 - Spiritual(smudging, praying, meditation, offering tobacco)

- Emotional (writing in my journal, sharing in the circle)

Wanaki Structure Responsibility

- Respect safety procedures which will be shared with you during the tour of the facility
 - There is a register to be signed at the front exit if I intend to leave the center for an outdoor activity.
 - I understand that I must remain on the Wanaki grounds unless I am accompanied by a member of the Wanaki team.
- Kitchen duty: there are 2 residents to help in the kitchen, set the table, clean the kitchen area and dining room, clean the pots and pans, load the dishwasher and take the garbage outside. These 2 residents are also responsible for placing the chairs in the program room. Please advise us if you are sick. The schedule will be posted in the kitchen.
- Please note that the kitchen will be locked at 6:00 PM daily. Snacks are provided in the dining area.
- A laundry schedule will be posted in the kitchen. You will be sharing the washer and dryer with your roommate on the day you have kitchen duties. Laundry hours are from 4:00pm to 10:00pm
- Television hours are posted beside the television sets.
- For safety reasons, you are not permitted to use any personal music devices such as an MP3, an iPod etc.
- Junk food in the center:
 - We try to promote health eating so we ask that you don't bring in any junk food into the Center.
- When fishing please catch and release. (Please ask staff for further info.)

Respect

- I will respect the elders and their teachings.
- I am committed to respecting my own personal boundaries and that of the others.
- I will respect the personnel and Wanaki property.
- I will respect confidentiality.

- I will respect cultural and spiritual diversity.
- I will treat my colleagues as brothers and sisters.
- I will respect appropriate dress wear within the centre and not wear clothes with logos that can be perceived as offensive or promoting drugs/alcohol.
- I will use appropriate language and manners.

I _____, have reviewed these in-house responsibility. I also understand that if certain rules are not respected, this will result in an infraction report or my termination from the center.

**APPLICATION FOR SERVICES
RELAPSE PREVENTION PROGRAM 2015**

CRITERIA FOR APPLYING:

- ATTAINED ABSTINENCE FOR A PERIOD OF 3 MONTHS DURING A ONE YEAR PERIOD. WE ASK THAT THEY BE ABSTINENT FOR 2 WEEKS BEFORE ARRIVING.
 - NOT MANDATED BY THE COURTS
 - MOTIVATED TO CONTINUE ON THEIR HEALING JOURNEY
-
-

DATE OF THE APPLICATION: ____/____/____
DAY MONTH YEAR

FILE NUMBER: _____

IDENTIFICATION OF THE APPLICANT

NAME: _____ **FIRST NAME:** _____

DATE OF BIRTH: ____/____/____
DAY MONTH YEAR

AGE: _____

☐ **MALE** ☐ **FEMALE**

1- HOME ADDRESS:

NUMBER

STREET

APARTMENT

CITY

PROVINCE

POSTAL CODE

PHONE NUMBER: HOME: () ____/____/____ CELLPHONE: () ____/____/____

2- FIRST LANGUAGE:

☐ FRENCH ☐ ENGLISH

☐ ABENAKI

☐ ALGONQUIN

☐ ATIKAMEKW

☐ CREE

☐ MI'GMAQ

☐ MOHAWK

☐ INNU

☐ NASKAPI

☐ INUKTITUT

☐ OTHER, PLEASE SPECIFY: _____

3- LANGUAGE OF USE:

☐ FRENCH

☐ ENGLISH

☐ OTHER, PLEASE SPECIFY: _____

4- HEALTH INSURANCE NO.: _____

EXPIRATION: ____/____
YEAR MONTH

☐ RENEWAL REQUEST TO BE MADE ON: ____/____/____
DAY MONTH YEAR

5- BAND NUMBER: _____

EXPIRATION: ____/____
MONTH YEAR

☐ RENEWAL REQUEST TO BE MADE ON: ____/____/____
DAY MONTH YEAR

7- CIVIL STATUS: ☐ SINGLE

☐ MARRIED

☐ WIDOWED

☐ DIVORCED

☐ COMMON-LAW

8- NUMBER OF DEPENDENT CHILDREN: _____ **CUSTODY:** ☐ SHARED ☐ FULL-TIME

9- NUMBER OF CHILDREN IN FOSTER CARE: _____

PLACEMENT AGENCY NAME: _____

FOSTER CARE WORKER NAME: _____

PHONE#: () _____ / _____

10- SPECIFY THE CHILDREN'S AGES: 1- ____ 2- ____ 3- ____ 4- ____ 5- ____

11- OCCUPATION: ☐ FULL-TIME EMPLOYMENT ☐ PART-TIME EMPLOYMENT ☐ UNEMPLOYED
☐ FULL-TIME STUDIES ☐ PART-TIME STUDIES ☐ AT HOME
☐ VOLUNTEER ☐ OTHER: _____

12- NUMBER OF SCHOOL YEARS COMPLETED: _____

13- MOTHER OR GUARDIAN: _____
LAST NAME (AT BIRTH) FIRST NAME

14- FATHER OR GUARDIAN: _____
LAST NAME FIRST NAME

15- SPOUSE: _____
LAST NAME (AT BIRTH) FIRST NAME

16- CONTACT IN CASE OF EMERGENCY: _____ **PHONE#:** () _____ / _____
CELL #: () _____ / _____

RELATIONSHIP: ☐ PARENTS ☐ SIBLING ☐ FRIEND ☐ OTHER-SPECIFY: _____

CAN WE LEAVE A MESSAGE? ☐ YES ☐ NO **IF SO, TO WHOM?** _____

17- APPLICANT'S AVAILABILITY: ☐ AM ☐ PM ☐ EVENING **PERSON WITH REDUCED MOBILITY:** ☐ YES ☐ NO

18- HAVE YOU EVER RECEIVED ADDICTIONS SERVICES? ☐ YES ☐ NO

19- HAVE YOU EVER BEEN FOLLOWED EXTERNALLY? ☐ YES ☐ NO **IF SO, SPECIFY:** _____

20- HAVE YOU EVER BEEN IN THERAPY? ☐ YES ☐ NO **IF SO, NUMBER OF TIME:** _____

IF SO, DATE OF THE LAST THERAPY: ____ / ____ / ____ **DURATION OF THERAPY:** _____
DAY MONTH YEAR

LOCATION: ☐ WAPAN ☐ WANAKI ☐ ONEN'TO: KON
☐ MIAM UAPUKUN ☐ MAWIOMI ☐ WALGWAN
☐ OTHER, PLEASE SPECIFY: _____

21- DID YOU OR YOUR PARENTS EVER ATTEND A RESIDENTIAL SCHOOL? ☐ YES ☐ NO

22- HAVE YOU EVER HAD A PERIOD OF ABSTINENCE? ☐ YES ☐ NO **IF SO, HOW LONG?** _____

WHERE? ☐ COMMUNITY ☐ IN CENTRE ☐ OTHER: _____

ANYTHING ELSE TO ADD: _____

PATTERN OF RELAPSE

WHAT DOES RELAPSE MEAN TO YOU?

WHEN DID YOU FIRST CONSIDER RELAPSE?

WHAT (IS HAPPENING THAT HAS CAUSED YOU TO THINK OF RELAPSE) HAPPENED THAT CAUSED YOU TO RELAPSE?

ARE THERE ANY TRIGGERS, WARNING SIGNS OR AT RISKS PLACES THAT YOU BELIEVE IMPACTED YOUR RELAPSE?

- ☐ PEOPLE THAT USE
 - ☐ BARS
 - ☐ MY FAMILY
 - ☐ BOREDOM
 - ☐ MUSIC
 - ☐ FEAR OF CHANGES
 - ☐ LACK OF SUPPORT
 - ☐ ISOLATION (IN ABSTINENCE)
 - ☐ GRIEF
 - ☐ LIFE PRESSURES (STRESS) - LEGAL
 - ☐ FINANCIAL PROBLEMS
-
- ☐ NOT CHANGING FRIENDS, PARTNERS
 - ☐ PEER PRESSURE (WEAK BOUNDARIES) – BULLYING
 - ☐ LACK OF MOTIVATION
 - ☐ LACK OF FEELING SECURE
 - ☐ UNRESOLVED ANGER
 - ☐ FALSE HOPES
 - ☐ UNRESOLVED TRAUMA
 - ☐ NOT ENOUGH EDUCATION AROUND LIFE SKILLS

WHAT DO YOU WANT TO WORK ON WHILE YOU'RE IN TREATMENT?

- ☐ COMMUNICATION
- ☐ CONFLICT RESOLUTION
- ☐ BOUNDARIES
- ☐ GAMBLING
- ☐ ANGER
- ☐ FEAR
- ☐ PHYSICAL ASPECT
- ☐ TIME MANAGEMENT
- ☐ BUDGETING
- ☐ WHO AM I (SELF-ESTEEM VS SELF-IMAGE)
- ☐ PROBLEM SOLVING
- ☐ DEALING WITH BOREDOM
- ☐ POSITIVE REINFORCEMENT
- ☐ HOW TO ACCEPT SUCCESS
- ☐ WHAT DO YOU USE TO COPE? - SELF-AWARENESS

WHAT ARE YOUR STRENGTHS AND POINTS TO IMPROVE ON?

HOW MUCH POWER HAVE YOU GAINED OVER YOUR SUBSTANCE 1-10:

ALCOHOL _____

DRUGS _____

GAMBLING _____

HOW WOULD YOU GAGE YOUR CRAVINGS ON A SCALE OF 1-10?

TELL US IN YOUR OWN WORDS WHY WE SHOULD ACCEPT YOUR APPLICATION.

BY WHO WERE YOU REFERRED?

- OTHER, PLEASE SPECIFY:** _____

LAST NAME	FIRST NAME
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PHONE#: () _____ - _____

ADDICTION ISSUE

- OTHER, PLEASE SPECIFY:** _____

DEVELOPED ANOTHER EXCESSIVE BEHAVIOUR? ☐YES ☐NO

DO YOU HAVE SOMEONE IN YOUR ENTOURAGE WHO IS STRUGGLING WITH ONE OF THE FOLLOWING PROBLEMS?

OTHER, SPECIFY: _____

PART 1

COMPLETED BY: _____ DATE: _____/_____/_____

TITLE: _____

PHONE#: () ____/_____

PLEASE PRINT YOUR NAME.

PLEASE PRINT YOUR NAME.

☐ YES ☐ NO

26-CONSUMPTION

SUBSTANCES	FREQUENCY OVER THE PAST 3 MONTHS (#1)	FREQUENCY IN THE LAST WEEK (#1)	QUANTITY PER DAY	ADMINISTRATION METHOD (#2)	HOW LONG HAS YOUR CONSUMPTION BEEN PROBLEMATIC?	DATE OF THE LAST CONSUMPTION?
DEPRESSANTS						
ALCOHOL (BEER, WINE,...)						_/_/_/ D M Y
INHALANTS (GAS, GLUE...)						_/_/_/ D M Y
STIMULANTS						
AMPHETAMINE (SPEED, PEANUT, CRYSTAL METH, RITALIN...)						_/_/_/ D M Y
COCAINE (POWDER, FREEBASE, CRACK...)						_/_/_/ D M Y
DISRUPTIVES						
CANNABIS (WEED, HASH...)						_/_/_/ D M Y
ECSTASY (MDMA)						_/_/_/ D M Y
P.C.P.						_/_/_/ D M Y
KETAMINE						_/_/_/ D M Y
PSILOCYBINE (MAGIC MUSHROOM)						_/_/_/ D M Y
L.S.D. (BLOTTER, ACID...)						_/_/_/ D M Y
DRUGS: SEDATIVES / ANALGESICS						
ANXIOLYTICS (XANAX, ATIVAN, LORAZEPAM, DIAZEPAM, VALIUM)						_/_/_/ D M Y
HYPNOTICS (DALMANE, RESTORIL, HALCION, MOGADON...)						_/_/_/ D M Y
BARBITURATES (FIORINAL, SÉCONAL, PHÉNOBARBITAL...)						_/_/_/ D M Y
OPIATES (OXYCONTIN, CODÉINE, DEMEROL, DILAUDID, MORPHINE...)						_/_/_/ D M Y
METHADONE (ALTERNATIVE TREATMENT FOR OPIATES)						_/_/_/ D M Y
DRUGS: ANTIPSYCHOTICS / ANTIDEPRESSANTS / MOOD STABILIZERS						
ANTIPSYCHOTICS (SEROQUEL, RISPERDAL, ZYPREXA)						_/_/_/ D M Y
ANTIDEPRESSANTS (CELEXA, PAXIL, PROZAC, ZOLOFT...)						_/_/_/ D M Y
MOOD STABILIZERS (LITHIUM, EPIVAL, TEGRETOL)						_/_/_/ D M Y
OTHERS						
SPECIFY: _____						_/_/_/ D M Y

LEGEND #1 CONSUMPTION FREQUENCY	
1.	EVERY DAY
2.	3 TIMES AND + PER WEEK
3.	ONCE OR TWICE PER WEEK
4.	ON WEEKEND
5.	OCCASIONNALLY

LEGEND #2 ADMINISTRATION METHOD	
1.	ORAL
2.	NASAL
3.	SMOKED
4.	INJECTED <input type="checkbox"/> INTRAMUSCULAR OU <input type="checkbox"/> INTRAVENOUS
5.	OTHER, SPECIFY: _____

PSYCHOLOGICAL STATE

HAVE YOU EVER BEEN FOLLOWED BY A MENTAL HEALTH PROFESSIONAL?

☐ YES ☐ NO

☐ NAADAP WORKER

☐ PSYCHOLOGIST IN COMMUNITY

☐ COUNSELLOR IN COMMUNITY

☐ MENTAL HEALTH WORKER

COULD WE HAVE ACCESS TO YOUR FILES? ☐ YES ☐ NO

DO YOU HAVE A MENTAL HEALTH DIAGNOSIS?

☐ YES ☐ NO

IF SO, PLEASE SPECIFY: _____

HAVE YOU EVER EXPERIENCED ANY OF THESE PROBLEMS?

REASONS	CURRENTLY	PREVIOUSLY	COMMENTS
SUICIDAL IDEATION	<input type="checkbox"/>	<input type="checkbox"/>	
ATTEMPTED SUICIDE	<input type="checkbox"/>	<input type="checkbox"/>	
SELF-MUTILATION	<input type="checkbox"/>	<input type="checkbox"/>	
FEELINGS OF DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	
DEEP ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	
BEHAVIOURAL PROBLEM (AGGRESSIVENESS, ACTING OUT, VIOLENCE)	<input type="checkbox"/>	<input type="checkbox"/>	
LOSS OF INTEREST/ LACK OF MOTIVATION	<input type="checkbox"/>	<input type="checkbox"/>	
HALLUCINATIONS/PARANOIA	<input type="checkbox"/>	<input type="checkbox"/>	
ISOLATION	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL PHOBIA	<input type="checkbox"/>	<input type="checkbox"/>	
DELIRIUM	<input type="checkbox"/>	<input type="checkbox"/>	
EATING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	
SLEEPING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER: _____	<input type="checkbox"/>	<input type="checkbox"/>	

DO YOU TAKE MEDICATION?

☐ YES ☐ NO

IF SO, PLEASE SPECIFY: _____

WHO IS YOUR PHYSICIAN?

PROFESSIONAL : _____ / _____	
NAME	TITLE
PHONE#: () _____ - _____	
DATE: _____	
LAST VISIT: _____ / _____ / _____	NEXT APPOINTMENT: _____ / _____ / _____
DAY MONTH YEAR	DAY MONTH YEAR

CULTURAL AND SPIRITUALITY

WHAT SPIRITUAL/RELIGIOUS BELIEFS DO YOU FOLLOW?

ARE YOU INTERESTED IN LEARNING GENERIC ALGONQUIN FIRST NATION CULTURAL AND SPIRITUAL TEACHINGS?

☐ YES ☐

NO

NOTE: THE CLIENT WILL NEED TO BE PRESENT FOR THE CEREMONIES, BUT WILL NOT NEED TO BE AN ACTIVE PARTICIPANT.

PHYSICAL CONDITION

MEDICAL CONDITIONS TO MONITOR OVERSEE

ARE YOU PREGNANT? ☐ YES ☐ NO **IF SO, SINCE HOW LONG?** ____/MONTH(S)

DO YOU HAVE A CHRONIC DISEASE?

- | | | | |
|---|------------------------------------|---|--|
| <input type="checkbox"/> HIV | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART DISORDER | <input type="checkbox"/> LUNG DISORDER |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> TUBERCULOSIS (TB) <input type="checkbox"/> OTHERS: _____ | | | |

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO

IF SO, WHAT ARE YOU'RE ALLERGIES? _____

ARE YOU BEING MEDICALLY-MONITORED FOR CHRONIC DISEASES MENTIONED ABOVE OR OTHER? (CURRENTLY)

☐ YES ☐ NO

IF SO, WAS YOUR PHYSICIAN ADVISED OF YOUR SERVICES REQUEST? ☐ YES ☐ NO

PROFESSIONAL : _____ / _____	
NAME	TITLE
PHONE#: () _____ - _____	
DATE: _____	
LAST VISIT: _____ / _____ / _____	NEXT APPOINTMENT: _____ / _____ / _____
DAY MONTH YEAR	DAY MONTH YEAR

ARE YOU TAKING MEDICATION FOR PHYSICAL PROBLEMS?

☐ YES ☐ NO

IF SO, SPECIFY: _____

ARE YOU EXPERIENCING TROUBLE SLEEPING?

☐ YES ☐ NO

IF SO, PLEASE SPECIFY: _____

37- ARE YOU EXPERIENCING TROUBLE EATING?

☐ YES ☐ NO

IF SO, PLEASE SPECIFY: _____

LEGAL SITUATION:

DO YOU PRESENTLY HAVE ANY LEGAL ISSUES?	YES	NO
A. ARE YOU ON PAROLE?	YES	NO If YES, UNTIL (Y/M/D): _____
B. ARE YOU ON PROBATION?	YES	NO If YES, UNTIL (Y/M/D): _____
C. IS THIS A COURT ORDER TO ATTEND TREATMENT?	YES	NO
D. ARE THERE ANY OTHER COURT APPEARANCES REQUIRED?	YES	NO If YES, UNTIL (Y/M/D): _____
E. HAVE YOU EVER BEEN INCARCERATED?	YES	NO If YES, HOW LONG AGO: _____
F. WHAT WERE THE CHARGES?	_____	
G. ARE THERE ANY PENDING CHARGES?	_____	

IF YOU ANSWERED YES TO A OR B, PLEASE PROVIDE THE CONDITIONS FOR PAROLE OR PROBATION. IF YOUR ARE REQUIRED TO APPEAR IN COURT PLEASE INDICATE THE DATE:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

INTERVENER OBSERVATIONS

PLEASE NOTE YOUR COMMENTS FOLLOWING THE MEETING WITH THE CLIENT: (EX: NERVOUS, INCOHERENT, POOR HYGIENE...)

FILE REFERRAL

A. ☐ INDIVIDUAL MEETING

ANTICIPATED DATE: _____

B. ☐ NURSE

PLEASE SPECIFY: _____

C. ☐ OTHER FIRST-LINE INTERVENER PLEASE SPECIFY: _____

D. ☐ REHABILITATION CENTRE

ANTICIPATED DATE: _____

E. ☐ EXTERNAL RESOURCES

PLEASE SPECIFY: _____

F. ☐ OTHER RESOURCES

PLEASE SPECIFY: _____

COMMENTS

PART 2

COMPLETED BY: _____ DATE: ____/____/____

DAY MONTH YEAR

TITLE: _____

PHONE#: () ____/____

PLEASE PRINT YOUR NAME

IF CLIENT IS BEING REFERRED FOR TREATMENT CENTER AND THE APPLICATION FORM IS COMPLETED, IT MUST BE SENT TO THE TREATMENT CENTER BY FAX OR REGULAR MAIL.

Client Signature

Date

Referral Signature

Date