Mistahey Musqua Treatment Centre

ADULT RESIDENTIAL TREATMENT REFERRAL FORM

- This form is to be completed by the referring NNADAP Worker or another referral agent.
- **Please refer to one treatment Centre at a time**. You will be notified when the application has been approved.
- **If you have applied to more than one treatment Centre for your client, please notify the other Centre(s) when the application has been approved so other treatment Centre beds are not being held for your client**.
- The medical assessment must be completed by a physician, nurse practitioner or registered nurse AAP.
- **ALL SECTIONS MUST BE COMPLETED**. **INCOMPLETE APPLICATIONS WILL BE RETURNED.**
- **Please email to intake@mistahey.net or fax (306) 837-4414.**

Treatment Centre Use Only:

Registration Date: (D/M/Y) ___/___/___

Admission Date: (D/M/Y) ___/___/___

Client File Number: _____

Cancellation Date: (D/M/Y) ___/___/___

INTAKE/REFERRAL APPLICATION

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA.

<table>
<tr><td colspan="4">A. General Information</td></tr>
<tr><td colspan="2">Date Application Received by Community Worker</td><td colspan="2">Date Application Received by Treatment Centre</td></tr>
<tr><td colspan="2">Surname:</td><td colspan="2">First Name:</td></tr>
<tr><td>Date of Birth:</td><td>Age:</td><td>Sex:</td><td>Provincial Heath Card Number:</td></tr>
<tr><td>Telephone:</td><td>Email:</td><td></td><td></td></tr>
<tr><td colspan="2">Mailing address:</td><td>Gender:
☐ Female/Woman
☐ Male/Man
☐ Transgender
☐ Intersex
☐ Two-Spirited
☐ Gender Fluid
☐ No category describes me
☐ Unknown
☐ Decline to state</td><td></td></tr>
<tr><td>Language Spoken:</td><td>Language Preferred:</td><td colspan="2">Language Understood:</td></tr>
<tr><td colspan="2">Emergency Contact Name:</td><td>Telephone:</td><td>Relationship:</td></tr>
<tr><td>Status Indian:</td><td>Status Number:</td><td colspan="2">Band Name:</td></tr>
<tr><td>Education:</td><td>Literacy Level:</td><td colspan="2">Employment Status:</td></tr>
<tr><td colspan="4">Does the client require assistance with reading?
☐ Yes
☐ No</td></tr>
<tr><td colspan="4">Does the client require assistance with writing?
☐ Yes
☐ No</td></tr>
<tr><td colspan="4">Has the client been diagnosed with any learning problems/disabilities?
☐ Yes
☐ No

If yes please describe:</td></tr>
</table>

Living Situation:	☐ On-reserve ☐ Off-reserve ☐ Urban ☐ Rural ☐ Immediate Family ☐ Extended Family ☐ Lives Alone ☐ Homeless ☐ Group Home ☐ Shelter ☐ Foster Care ☐ Common Law ☐ Friend

Family/Relationships

Marital Status:	
Does Client have dependent children?	☐ Yes ☐ No

If yes, do they have access to adequate childcare while in treatment?	☐ Yes ☐ No ☐ Not Applicable	
Are the children in care?	☐ Yes ☐ No ☐ Not Applicable	
Does the client have other dependents?	☐ Yes ☐ No	

Provide information on client's children or other dependents:

Name	Age	Relationship

Family Supports:
Family Strengths:

Legal Status	
Has client been court ordered to attend treatment?	☐ Yes ☐ No
If yes, provide details (include details/copy of Probation Order if applicable and/or available):	
Legal System Involvement:	☐ Criminal Court ☐ Family Court ☐ Drug Court Treatment ☐ Probation ☐ Charges Pending ☐ Court Referral ☐ Court Order ☐ Restorative Justice
Is the client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temporary Absence Order
Other (provide details, dates, etc.):	

Treatment History	
Has client participated in a non-residential/community based substance abuse program?	☐ Yes ☐ No
Has client participated in a non-residential/community based mental health program?	☐ Yes ☐ No
Has client participated in a residential treatment program before?	☐ Yes ☐ No
If yes, please provide information on previous treatment experience:	

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
Reason(s) for currently requesting treatment:				

B. Withdrawal Symptoms
Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptom		Describe
Blackouts	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

Hallucinations	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Nausea/Vomiting	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Seizures	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Shakes	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Delirium Tremens (DT's)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Ever experienced DTs?	☐ Yes ☐ No	

C. Process/Behavioural Addictions

Has client experienced problems with any of the following?

Process/Behavioural Addiction		Describe
Gambling (slots, cards, Keno, bingo, etc)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Sex (promiscuity, etc.)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Internet/texting	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

Other	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

D. Mental Health Issues

Provide the following information about the clients health status:

Mental Illness		**Describe**
Been diagnosed with a mental illness	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Currently being treated	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Currently on psychiatric medication	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Taking medication consistently	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Previous suicide attempts/ideation	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, when?		

Hospitalized for suicide attempts	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, when?		
Currently suicidal	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Name of psychiatrist/psychologist (if applicable):		

E. Other Issues/Needs	
Does client have cultural and/or spiritual beliefs and practices we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Are there any other significant issues we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Does client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment?	☐ Yes ☐ No
Does client understand there is an expectation they have been alcohol and drug free for at least 7 days prior to admission of residential treatment (or 14 days if withdrawing from benzodiazepines). (Client with less than the required days must notify the treatment centre prior to admission). Client will be drug tested on arrival; any positive results and the client will be denied acceptance into the program.	☐ Yes ☐ No
Personal Strengths:	

F. Application Checklist	
Confirmation of transportation to Treatment Centre through referral	☐ Yes ☐ No
Confirmation of transportation back home	☐ Yes ☐ No
Client has been notified and understands the Non-Insured Health Benefits policy change whereby anytime during treatment and the client self-terminates, or the Treatment Centre terminates the client, and medical transportation benefits have been provided, the client will have to assume the costs of the next trip to access medically required health services and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada.	☐ Yes ☐ No

Client Authorization	
I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by the Treatment Centre.	
Client Signature	**Date**
Referral Signature	**Date**

REFERRAL INFORMATION				
Has the client completed four pre-treatment appointments?				☐ Yes ☐ No
Please provide appointment dates:	Date 1:	Date 2:	Date 3:	Date 4:
Will you continue to see the client once he/she has completed treatment?				☐ Yes ☐ No

What other supports would be available to your client in their community upon completion of treatment?	
Name/Resource	**Description of Support**

Please provide/attach a brief assessment summary, (Assessment Summaries completed within 6 weeks of this application may be substituted and attached) including summarization of any assessment processes completed with the client (e.g. SASSI, MAST, DAST, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, school, psychological, spiritual, emotional).

Client's Stage of Readiness:

☐ Pre-contemplation - Not considering change; resistant to change
☐ Contemplation - Unsure of whether or not to change; chronic indecision
☐ Determination - Preparation; committed to changing behaviour within one month
☐ Action - Begin changing behavior
☐ Maintenance - Behaviour change has persisted for 6 months or more

Please list any questions or concerns the client has indicated during the intake process:

What other areas might need to be addressed in treatment? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):

Referral Agent assessment of client's strengths and potential challenges for completing treatment:

Referral Checklist

Please initial which applicable items have been completed. Check off any items attached to this application:

Item	Attached	Initials
Psychiatric evaluations	☐ Yes ☐ No	
Probation order	☐ Yes ☐ No	
Current Medical Assessment Forum	☐ Yes ☐ No	

Assessment Summary	☐ Yes ☐ No	
Substance Abuse Profile	☐ Yes ☐ No	
Please initial each item that has been completed:		
Item		**Initials**
Confirmation of transportation to the treatment centre		
Confirmation of transportation back home after completion of treatment		
All medical, dental and optical appointments have been dealt with prior to treatment		
All financial matters have been dealt with prior to treatment		
All legal matters have been dealt with prior to treatment		
Referral Signature	Date (D/M/Y)	

MISTAHEY MUSQUA TREAMENT CENTRE

MEDICAL EXAMINATION FORM

THIS MEDICAL EXAMINATION FORM HAS TO BE COMPLETED BY LICENSED PHYSICIAN, NURSE PRACTITIONER or RN AAP AND ATTACHED TO THE APLICATION FORM.

CLIENT INFORMATION

First Name: _____Last Name: _____

Nickname(s): _____Address: _____

DOB: _____Health Card Number: _____Gender: M ___F ___

PHYSICIAN INFORMATION

First Name: _____Last Name: _____

Address: _____Phone: _____Fax: _____

Please check yes or no to indicate if client is currently being treated for or if He/She has a history of any of the following:

CONDITIONS	WHEN AND GIVE DETAILS IF APPLICABLE		
Tuberculosis	☐ YES	☐ NO	
Heart Disease	☐ YES	☐ NO	
Mental Illness	☐ YES	☐ NO	
Epilepsy	☐ YES	☐ NO	
Seizure (Other that epilepsy)	☐ YES	☐ NO	
High Blood Pressure	☐ YES	☐ NO	
Cancer	☐ YES	☐ NO	
Allergy	☐ YES	☐ NO	
Stroke	☐ YES	☐ NO	
Diabetes	☐ YES	☐ NO	
Back Pain	☐ YES	☐ NO	
Venereal Disease	☐ YES	☐ NO	
Emphysema or other lung disease	☐ YES	☐ NO	
HIV/AIDS	☐ YES	☐ NO	
Hepatitis A, B, C	☐ YES	☐ NO	
Scabies	☐ YES	☐ NO	
Lice	☐ YES	☐ NO	
Pregnancy	☐ YES	☐ NO	LMP / /20 Live births:

Please indicate current medications for medical reasons; the MMTC will not accept unnecessary prescription drugs or over the counter drugs and clients requiring acute care or detoxification services.

CURRENT MEDICATIONS	DOSAGE	REASON/COMMENTS

PLEASE LIST ANY FURTHER INFORMATION THAT YOU THINK MAY BE OF BENEFIT TO THIS CENTRE

****IF A FULL PHYSICAL EXAMINATION WAS DONE PLEASE PROVIDE A COPY****

Nurse or Doctor Signature: _____Date: _____

I UNDERSTAND THAT I GIVE AUTHORIZATION TO RELEASE ANY MEDICAL INFORMATION TO MMTC FROM THE ABOVE HEALTH PROVIDER

Patient Signature: _____Date: _____

MISTAHEY MUSQUA TREATMENT CENTRE

CONSENT TO RELEASE INFORMATION

I _____ HEREBY AUTHORIZE MISTAHEY MUSQUA TREATMENT CENTRE AND ITS STAFF, TO RELEASE THE FOLLOWING INFORMATION:

- MLTC Electronic Medical Records – Information is entered into the EMR
- Lakeside Pharmacy – All medications are ordered through this pharmacy
- MLTC Program and Services
- MMTC Program
- Referral Agent
- Penny Frazer – Mental Health Therapist
- Addictions Management Information System – Information is entered into the AMIS Program
- Indigenous Service Canada – For Statistics Information

ALL PRECAUTIONS TO MAINTAIN CONFIDENTIALTY OF THE INFORMATION WILL BE TAKEN AND NO OTHER PERSONS WILL HAVE ACCESS TO IT WITHOUT FURTHER WRITTEN CONSENT EXCEPT AS REQUIRED BY LAW.

_____ _____

CLIENT NAME CLIENT SIGNATURE

_____ _____

WITNESS NAME WITNESS SIGNATURE

What may be brought to Treatment?

- Photo Identification – health card, status card, etc.
- This list is meant to inform you of what you should/can bring.

- Casual, comfortable clothing and indoor footwear.

- Please bring appropriate clothing for weather.

- Sweat/ceremonial clothing – i.e.: ankle-length dress of skirt and t-shirt for sweats/ceremonies for women. Sweats or shorts for men for sweats/ceremonies.

- Towels and face cloths.

- Personal toiletries – shampoo, conditioner, toothbrush, toothpaste, deodorant, -hairbrush, comb, shavers, nail clippers, etc. enough female products

- Calling cards, cigarettes

- List of names and contact info for doctor(s), mental health providers, lawyers, social workers, family support members, organizations in your network.

- Bubble packed prescription(s), if any, to be bubble-packed for your 5 weeks stay. MMTC will make arrangement with Lakeside Pharmacy in Loon Lake and delivery on day two

- Sentimental items such as photo albums, encouraging letters, cards, etc.

- An open mind.

What may Not be brought to Treatment:

- Weapons of any kind.
- Mouthwash with alcohol content/alcohol hairspray.
- Hair dyes.
- Pornographic material.
- Cellphones and/or other electronic devices.
- Alcohol and/or any illegal substances

- Clothing with explicit messages or photos.
- **Absolutely no seeds/nuts (sunflower, pumpkin, etc.) Food Items Energy Drinks (Gatorade) or tablets.**
- Closed mind.

LUGGAGE CHECKLIST
NOT ALLOWED IN THE BUILDING: (Will be discarded.)

- Drugs or drug paraphernalia and Alcohol or alcohol paraphernalia
- Unapproved medication (narcotics and benzodiazepines will be discarded by the pharmacist)
- Hand sanitizer containing alcohol.
- TO BE TAKEN AND PUT AWAY UPON ADMISSION (Put in client cubby, labeled, and locked in counsellor office) these items will be returned to clients upon discharge.
- Weapons (pocketknives, ornamental swords, tools, etc.)
- Over the Counter medications that are not approved.
- Electronic equipment (Cellphones, mp3's, iPod/iPad, Laptops, handheld games, cameras, alarm clocks)
- Lottery tickets or gambling paraphernalia
- Colognes/perfumes, Nail polishes/removers and nail glue, Hair dye and alcohol hairspray
- Clothing with drug/alcohol/gambling or sexually suggestive images and words
- Movies and DVD's
- Pornography Magazines and sexual devices
- Lighter Fluid
- Weight altering substances.
- **No e-cigarettes, chewing tobacco and snuff to be used in the facility**

TO BE KEPT IN CLIENTS BASKET (In Counsellor Office)

- Valuables (Jewelry, wallet, money, hair curlers/straighteners)
- Extra cigarettes
- Razors, shaving kits, nail clippers (manicure sets, tweezers, etc.)

TO BE KEPT BY THE CLIENT (In client room)

- Hair products (like non-alcohol mousse and gel) and Bath products
- Toothbrush and Toothpaste
- Make up – All cosmetic products must be alcohol free.
- Alcohol free mouth wash
- Diabetic testing kit

MAY BE KEPT BY CLIENT PENDING MANAGER APPROVAL

- Inhalers
- Nitro-glycerine
- Epi-pens
- Some Prescription Creams
- Lozenges/Cough Drops (must be sealed in original packaging)