STONEY NAKODA ADULT TREATMENT CENTER

Unanswered questions, incomplete or illegible answers may delay your admission

APPLICATION FOR ADMISSION

The applicant should complete this form and have the referring person (if applicable) complete page ten (15).

The medical assessment on pages five to nine (7-13) must be completed by a medical doctor or nurse practitioner.

Return all pages by Fax to: (403) 881-0080

Application Requirements:

1. Application form completed and signed by the client
2. Application medical completed by referring physician or nurse practitioner (pages 7-13)

Admission Criteria:

In addition to clients being motivated, their ability to stop using substances, and having adequate family support, the following criteria apply to individuals being accepted to the SN-ATC:

Individuals May Be:

- Self-referred.
- Referred by a healthcare professional.
- Admitted with physical limitations.
- On Opioid Replacement Therapy (ORT) and / or psychiatric medications at time of admission.

Individuals Must:

- Remain alcohol and drug-free for a minimum of 7 days prior to admission and have completed detox.
- Be willing and able to actively engage in the 90-day Treatment Center Program.
- Be medically and psychiatric stable; cleared by a physician or nurse practitioner prior to admission (accepting women less than 5 months pregnant). Able to self-manage medication(s).
- Deal with all legal, medical, education, employment and childcare services issues prior to admission so that they will not interfere with your treatment program.

STONEY NAKODA ADULT TREATMENT CENTER

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Legal First Name *(last, first, middle):*		
What name do you prefer used?	Other Name *(e.g., maiden name or an alias):*	
Date of birth:	Age:	Health Care #:
Gender: ☐ Male ☐ Female ☐ Non-binary / Prefer not to disclose		
Marital Status: ☐ Single/Never married ☐ Married/Common-Law ☐ Divorced/separated ☐ Widowed		
Home Address:		
City:	Province:	Postal Code:
Mailing Address: (if not same as above)		
Phone #	Alternative #	
Treaty Status: (if applicable)		
Treaty:	Metis:	

STONEY NAKODA ADULT TREATMENT CENTER

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Band Name:	Treaty No:
Emergency Contact:	Phone Number:
Next Kin:	Relationship:
Next of Kin Primary Number:	Alternative Number:

Current Employment Status:

☐ Employed ☐ Unemployed ☐ Student

What is your occupation?

Who is your employer: (optional)

If you were referred to this program, check all that apply

- ☐ Addiction/Counseling Services
- ☐ Physician
- ☐ Child Welfare Worker
- ☐ Psychiatrist/Psychologist/Mental Health Worker
- ☐ Family
- ☐ Employer/Employee Assistance Program
- ☐ Social Services/Income Support Worker
- ☐ Court/Parole Office/Probation Officer/Lawyer
- ☐ AISH
- ☐ Other(specify)_____

Substance Use History:
Please describe in detail your alcohol and other substance use?
What substance(s) do you use commonly/currently?
What primary substance (s) do you use often?
Pattern of use of primary substance(s)? (e.g., daily, binge)
How long have you used substances for?
When did you last use? What?
What other substance(s) have you used in the past?

STONEY NAKODA ADULT TREATMENT CENTER

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Are you a Smoker? YES ☐ NO ☐	Do you use any vaping devices? YES ☐ NO ☐
Any other substance use or addiction-related concerns you wish to discuss?	
Are you currently experiencing any withdrawal symptoms?	
Treatment History:	
Have you previously attended treatment for addictions and, if so, when?	
Reason for previous treatment?	
If so, how long have you been alcohol or drug free?	
What are your reasons for wanting to attend treatment this time?	

What other concerns would you like to address in treatment? What would you like us to know about you?
Please describe in detail how this has affected your daily life: (e.g., family, relationships, employment, health)
Do you require additional support? (Reading, writing, English, wheelchair accessibility, hearing/eyesight difficulties, dietary restrictions, etc.). If yes, please describe it in detail.

STONEY NAKODA ADULT TREATMENT CENTER

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Medical assessment must be completed by a medical doctor or nurse practitioner. (Pages 7 – 13)

Medical Details:		
Patient name:	Date of Birth:	Health Care Number:
Medical Details:		
Family physician:	Phone #:	
Does the patient have allergies? (Medications, foods, environmental)		

Medications: List all medications that the patient is taking, including all over-the-counter drugs. (e.g., Gravol, Tylenol, NyQuil, allergy medications, vitamins, herbal remedies, etc.) Provide additional information on a separate sheet if needed.

Medication:	Dose:	Route:	Frequency:	Reason Given:	Start/End Date:

Physician Name:	Date:	Signature:

Medications Cont.:					

Are there any concerns of the following?	Yes/No	Comments
Developmental or learning disorder? (e.g., depression, anxiety, bipolar, ADHD, phobias, psychosis, schizophrenia)		
Acute medical conditions ?		
Physical disorders aggravating mental health?		
Related psychosocial and environmental concerns?		
Current or previous thoughts of suicide/self-harm attempted suicide? Provide details		
Is the patient psychologically stable to attend SN-ATC?		

Physician Name:	Date:	Signature:

The following medications are restricted at Stoney Nakoda Treatment Centre:

****Note: This list is not exhaustive and other medications may be subject to restriction. If you are stabilized on a medication or a stimulant, then this will be assessed case by case.**

Opioid Pain Medications • Codeine & Codeine containing products (e.g., Tylenol #3) • Morphine (e.g., Kadian) • Fentanyl • Hydromorphone (Dilaudid) • Oxycodone (Percocet, OxyNeo) • Meperidine (Demerol) • Tapentadol (Nucynta) • Tramadol (Zytram, Ralivia, Tridural) • Pentazocine (Talwin) • Propoxyphene (Darvon)	Benzodiazepines • Alprazolam (Xanax) • Bromazepam (Lectopam) • Lorazepam (Ativan) • Oxazepam (Serax) • Temazepam (Restoril) • Triazolam (Halcion) • Chlordiazepoxide (Librium) • Clonazepam (Rivotril) • Clorazepate (Tranxene) • Diazepam (Valium) • Flurazepam (Dalmane) • Nitrazepam (Mogadon)
Psychostimulants • Dextroamphetamine (Dexedrine) • Amphetamine Mixed Salts (Adderall XR) • Lisdexamfetamine (Vyvanse CASE BY CASE) • Methylphenidate (Ritalin, Biphentin, Concerta) • Modafinil (Alertec)	Miscellaneous • Varenicline (Champix) • Nabilone (Cesamet) • Dronabinol (Marinol) • Medical Marijuana • Zopiclone (Imovane, Zolpidem)

What if I am taking Methadone or Suboxone for opioid dependence treatment?

Individuals on the OAT program or medical cessation program are accepted at SN-ATC. Please note, that you would need to be on the medication for at least seven to fourteen days (7-14) with an active prescription for continuation once admitted to the treatment program. Initiation of a new prescription for medical cessation medication will be done after intake into the program. you will be admitted to the program with confirmation from your medical provider that you are a stable maintenance dose.

Physician Signature: _____

Patient initials: _____

Is the patient medically stable and ready for admission to SN-ATC?		
Psychiatric Review / History: Attach any evaluations, results and/or discharge summaries		
Please send relevant reports, e.g., CBC, Hepatic profile, electrolytes, urinalysis, etc.		
EENT		
Respiratory (asthma, COPD)	Cardiovascular	
Gastrointestinal	Genitourinary (e.g., incontinence, BPH, STD)	
Musculoskeletal (chronic pain, RA, OA, gout)	Integumentary	
Neurological:		
History of seizures:		
Physician Name:	Date:	Signature:

Hematological/Immune:	Evidence of withdrawal or intoxication?	
Physical examination		
Height:	Weight:	Temp:
Pupils:	Heart Rate:	BP:
Respiration:	Skin:	Diaphoresis:
Tremor:	Is patient diabetic:	Year diagnosed:
Is client stable:		
Does the patient have MRSA and wound?		
Specify latest swabs:		
Is there cognitive impairment?		
Needs assistance ambulating?		
Physician Name:	Date:	Signature:

STONEY NAKODA ADULT TREATMENT CENTER

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Is the patient pregnant?	LMP:
Physician managing pregnancy?	Location of delivery?

TB Screening and History:	Yes	No
Cough lasting more than 2 weeks?	☐	☐
Weight loss, if yes specify lbs and time	☐	☐
Night Sweats	☐	☐
Fever	☐	☐
Blood in sputum	☐	☐
Previous active TB and treatment	☐	☐
Previous chest x-ray results	☐	☐
Extensive travel	☐	☐
Other risk factors	☐	☐
Further TB screening/assessment required – if yes, send results	☐	☐
Medical Approval:		

Physician Name:	Signature:	Date:

Do you feel this patient is ready and could benefit attending SN-ATC? Explain?		
Is there anything you think we should know?		
Notes:		
Physician Name:	Signature:	Date:

STONEY NAKODA ADULT TREATMENT CENTER

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Legal Issues:	
Are you dealing with any criminal or legal matters before the court?	
What are the pending or legal issues charged with?	
If applicable, list upcoming court dates:	
Are you currently incarcerated? If yes, which location?	
Are you on probation, temporary absence (TA), or parole? If yes, provide details below *(offence type, parole probation officer, legal counsel, any other pertinent info)*	
Were you court ordered to attend treatment?	
Probation Order/Parole Conditions? ◯ YES / NO ◯ **IF YES, PLEASE ATTACH**	
Probation Officer Name:	Phone #:

STONEY NAKODA ADULT TREATMENT CENTER

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This section is to be filled out by the referring person (Self-referrals, skip this step)

Name of Referring Person:	Relationship:	Contact #.
Agency:	Agency Address:	Contact #.
Payment Method:	Status: Alberta Resident ☐ Status/Indigenous ☐ AISH ☐	

Carefully Read the Following:

- ☐ I understand that in order to be admitted to live-in treatment, I will remain alcohol and drug-free for at least six days (length of time may vary based on an assessment) before my admission date, and be well enough to participate in the program. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will then be referred to an appropriate detoxification setting before treatment.
- ☐ I understand Stoney Nakoda Adult Treatment Centre (SN-ATC) is not responsible for my transportation or any other personal costs I may incur (e.g., approved medications) while I am in treatment. I will bring and give to staff all medications I am taking.
- ☐ I understand that I will schedule only mandatory appointments prior to admission (legal, dental, medical, or personal) and disclose those appointments upon admission. As the focus is on my treatment program, exceptions will be made for specialist appointments.
- ☐ I understand and agree to accept and attend all components of the treatment program as prescribed by SN-ATC, including all workshops, lectures, leisure, and group counselling sessions.

Signature:	**Date: (yyyy-mm-dd)**