Stoney Health Services - Day Treatment Program (SHS-DTP)
Intake Form

Date:				
Name:		**Preferred Name:**		
DOB:	**Age:**	**Male:**	**Female:**	**Other:**
Address:		**Alarm #**		
Contact Info:		**AHC#/Band #:(Optional)**		

What are your reasons for wanting to attend treatment at this time?	
Do you have any special needs or challenges that you would like to share with us? (e.g., reading and writing English, vision problems, wheelchair accessibility, hearing difficulties, mobility concerns). If yes, provide details:	**No**
	Yes
Do you have any allergies? Yes: (List them)	**NO**
	Yes
Are you seeing a doctor regularly for any reason, including medication refills?	**Yes**
	No
Describe in detail how substance use/addiction challenges affected you or others, both in the past and currently.	
Are you mandated to attend treatment? If yes, are you requiring other resources and support?	**Yes**
	No

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What support and resources do you currently have access to? (e.g., counselling, harm reduction, family/friends, elders, others)			
This section to be completed by the referring source only;			
Referring Person's Name		**Agency/Department**	
Address		**City**	**Province**
Postal Code	**Phone Number**	**Fax Number**	
What is your assessment of the applicant's readiness and motivation for treatment at this time?			
In your professional assessment, what issues does the client need to focus on while in the program?			
Completed assessment form (e.g., SAGAA) attached			**Optional**
Referring Person's Signature:		**Date *(yyyy-Mon--dd)***	