Round Lake Treatment Centre (RLTC)
200 Emery Louis Road, Armstrong, BC V0E 1B5
www.roundlaketreatmentcentre.ca

RECOVERY HOME Application Package

Phone: 250-546-8848 / Fax: 250-546-3227
Email: Intake@roundlake.bc.ca

APPLICATION CHECKLIST FOR REFERRAL WORKER

Have You?

- ☐ Completed and sent the application for Recovery Home placement?
- ☐ Completed and sent the Resident Client Confidential Information Waiver?
- ☐ Completed and sent the Travel form?
- ☐ Given the Resident Client the list of what to bring and what not to bring?
- ☐ Included the three page pre-admission medical report?
- ☐ Attached TB Results?

If your Resident Client is on a Methadone dosage not exceeding 170 mg per day, have you?

- ☐ Completed and sent a signed copy of the Resident Client's Methadone Verification Form?
- ☐ Checked to ensure that your Resident Client is not taking unsafe medications?

If your Resident Client is receiving Income Assistance, have you?

- ☐ Forwarded the letter to the Employment and Income Assistance worker to sign?
- ☐ Assisted in securing Resident Client's contribution requirement to begin upon admission entry?

If your Resident Client is on probation or parole, have you?

- ☐ Forwarded a copy of the Probation or Parole Order?

Have you?

- ☐ Submitted necessary supporting documentation such as probation orders, pre-natal reports, etc.?

RESIDENT CLIENT CHECKLIST

- ☐ I have recently completed a treatment program and am clean from drugs and alcohol for ____ number of days or months (more sobriety/clean time is better!).
- ☐ I have return travel arrangements and am prepared to absorb the costs if I choose to leave the Supportive Recovery Home Program early or am discharged.
- ☐ I am willing to contribute to my transition plans immediately upon admission to ensure I increase my successful re-integration back into community.
- ☐ I have read, understand and accept the Recovery Home guidelines as outlined by Round Lake Treatment Centre.
- ☐ I have read and given copies of the Visitor Guidelines to all persons who may visit me.
- ☐ My medical coverage is currently active and includes prescription coverage.
- ☐ I have taken care of Doctor/Dentist/Eye appointments PRIOR TO MY ADMISSION.
- ☐ I am free of outside interference which requires my attention during the initial month of my stay at the recovery home.
- ☐ I have packed white soled or non-marking running shoes for indoor use and one pair for outdoors.
- ☐ I have packed exercise clothing – loose shorts or sweats, T-shirt, swimming suit or swimming shorts.
- ☐ I have shampoo, toothbrush/paste, soap, feminine products, and shaving supplies, etc.
- ☐ I have a bank card, identification (for cashing cheques) and a phone card (for long-distance calls).
- ☐ I have pens, pencils, writing paper, envelopes and stamps.
- ☐ I have ensured that all necessary documents are included in the application.

Round Lake Treatment Centre (RLTC)
200 Emery Louis Road, Armstrong, BC V0E 1B5
www.roundlaketreatmentcentre.ca

RECOVERY HOME Application Package

Phone: 250-546-8848 / Fax: 250-546-3227
Email: Intake@roundlake.bc.ca

NOTE: APPLICATION PACKAGE IS TO BE COMPLETED BY THE REFERRAL WORKER

PART 1 – CLIENT IDENTIFICATION

PLEASE PRINT CLEARLY

SURNAME (LEGAL)		FIRST NAME	MIDDLE NAME
ADDRESS		CITY, PROVINCE	POSTAL CODE
TELEPHONE		EMAIL	BIRTH DATE (YYYY / MM / DD) ☐ MALE ☐ FEMALE
ABORIGINAL ANCESTRY ☐ YES ☐ NO	BAND MEMBER ☐ YES ☐ NO	BAND NAME, INUIT, MÉTIS, ABORIGINAL COMMUNITY	ON RESERVE ☐ YES ☐ NO
STATUS NUMBER		SOCIAL INSURANCE NUMBER	CARE CARD NUMBER
HOW ARE MSP PREMIUMS PAID? ☐ FNHA ☐ MEIA ☐ SELF		HOW IS CLIENT CONTRIBUTION PAID? ☐ SOCIAL ASSISTANCE ☐ DISABILITY ☐ SELF ☐ BAND ☐ OTHER	HOW WILL TRAVEL BE PAID **TO** & **FROM** RLTC? ☐ SELF ☐ BAND ☐ OTHER:_____
EMERGENCY CONTACT SURNAME [1]		EMERGENCY CONTACT FIRST NAME	EMERGENCY CONTACT TELEPHONE
EMERGENCY CONTACT EMAIL		EMERGENCY CONTACT RELATIONSHIP TO CLIENT	

PART 2 – CLIENT INFORMATION

PLEASE PRINT CLEARLY

DOES THE CLIENT HAVE PHYSICAL LIMITATIONS THAT PREVENT THEM FROM DOING DAILY LIVING CHORES, RECREATIONAL OR CULTURAL ACTIVITIES?	☐ YES ☐ NO	DOES THE CLIENT REQUIRE A WHEEL CHAIR ACCESSIBLE BEDROOM AND/OR BATHROOM?	☐ YES ☐ NO
DOES THE CLIENT HAVE ANY SPECIAL NEEDS WE NEED TO BE AWARE OF?	☐ YES ☐ NO	PLEASE EXPLAIN	

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 CHILDREN (0-18 YEARS OF AGE): _____ AGES OF CHILDREN: ☐ 0 TO 4 ☐ 5 TO 9 ☐ 10 TO 13 ☐ 14 TO 18

DOES THE CLIENT HAVE SECURE CHILD CARE FOR AT LEAST THE SIX MONTHS? ☐ YES ☐ NO

HAS THE CLIENT BEEN MANDATED TO TREATMENT BY MCFD?	☐ YES ☐ NO	If YES, potential Resident Client understands RLTC is not obligated to admit them and they must be willing to adhere to the rules and guidelines of the program, are willing to partake fully in the program and address their children in care issue?	INITIALS _____
IS A SOCIAL WORKER CURRENTLY INVOLVED WITH THE FAMILY?	☐ YES ☐ NO	PLEASE EXPLAIN	

[1] Resident Client understands and accepts that Emergency Contact will be contacted in the event of an emergency

RESIDENT CLIENT NAME	DATE OF BIRTH

EMPLOYMENT STATUS

☐ FULL TIME ☐ PART TIME ☐ FULL TIME SEASONAL ☐ PART TIME SEASONAL ☐ UNEMPLOYED ☐ RETIRED ☐ STUDENT ☐ HOMEMAKER

OCCUPATION: _____ ☐ NOT IN LABOUR FORCE (DUE TO DISABILITY)

SOURCE OF INCOME: _____ (NOTE: IF Potential Resident CLIENT HAS NO SOURCE OF INCOME OR SECURE HOUSING PRIOR TO admission , ARRANGEMENTS TO APPLY FOR INCOME ASSISTANCE SHOULD BE MADE PRIOR to expedite admission process)

If Resident Client is currently working please describe arrangement made with their employer for the duration of their Recovery Home placement stay.

Part of the Recovery Home program may be assistance in obtaining employment or volunteer experience. Please answer the following as best as you can: If not employed, what areas of employment are of interest to the Resident Client?

What current employment skill does the Resident Client have or is interested in acquiring?

Does the Resident Client have any volunteer experience? If so please list:

EDUCATION STATUS

HIGHEST LEVEL COMPLETED: ☐ GRADE COMPLETED _____ ☐ HIGH SCHOOL DIPLOMA ☐ TRADE SCHOOL

☐ COLLEGE DIPLOMA ☐ UNIVERSITY DEGREE ☐ GRADUATE DEGREE

HAS THE RESIDENT ATTENDED RESIDENTIAL SCHOOL? ☐ YES ☐ NO	IF YES, FOR HOW LONG? _____
HOW DOES THE RESIDENT CLIENT DESCRIBE THEIR RESIDENTIAL SCHOOL EXPERIENCE?	
DOES THE RESIDENT CLIENT HAVE DIFFICULTY WITH READING? ☐ YES ☐ NO	DOES THE RESIDENT CLIENT HAVE DIFFICULTY WITH WRITING? ☐ YES ☐ NO
DOES THE RESIDENT CLIENT HAVE ANY LEARNING PROBLEMS/DISABILITIES? ☐ YES ☐ NO	WILL THE RESIDENT CLIENT REQUIRE ASSISTANCE WITH READING/WRITING?[2] ☐ YES ☐ NO
HAS THE RESIDENT CLIENT COMPLETED AA STEPS 1 TO 3? ☐ YES ☐ NO	DOES THE RESIDENT CLIENT AGREE TO THE RECOVERY HOME GUIDELINES? ☐ YES ☐ NO

[2] RLTC has the AA/NA Big Book and 12 x 12 on audio tape for Resident Clients who have literacy difficulties.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 3 – RESIDENT CLIENT LEGAL STATUS

PLEASE PRINT CLEARLY

ADMISSION CRITERIA FOR RESIDENT CLIENTS WITH LEGAL ORDERS ATTENDING ROUND LAKE TREATMENT CENTRE:

- We limit the number of individuals per intake who have current legal orders in place.
- Legal issues/court dates will be assessed on a case-by-case basis.
- The Resident Client is expected to cooperatively participate and follow all program and program guidelines with the understanding that we are under no obligation to keep a Resident Client who does not participate or comply with supportive recovery direction.
- We do not accept charged or convicted sex offenders.
- We do not accept potential Resident Clients with the following legal conditions:
    1. Electronic Monitoring
    2. Temporary Absence
    3. 24 Hour Supervision
    4. Day Parole
    5. All other legal conditions are reviewed on a case by case basis

CURRENT LEGAL STATUS IS **NOT APPLICABLE** ☐	DOES THE RESIDENT CLIENT HAVE ANY CURRENT LEGAL ORDERS IN PLACE? ☐ YES ☐ NO
IF YES, PLEASE SPECIFY THE TYPE OF LEGAL ORDER IN PLACE	
WERE THE CHARGES ALCOHOL/DRUG RELATED? ☐ YES ☐ NO	DOES THE CLIENT HAVE ANY PENDING CHARGES/COURT DATES? ☐ YES ☐ NO
NAME OF PROBATION OFFICER [3]	PROBATION OFFICER TELEPHONE
IF YES, PLEASE LIST ALL PREVIOUS CONVICTIONS/CHARGES AND DATES	

PART 4 – REFERRAL ASSESSMENT

PLEASE PRINT CLEARLY

HAS THE RESIDENT CLIENT ATTENDED RLTC BEFORE? ☐ YES ☐ NO	IF YES, DID THE CLIENT COMPLETE? ☐ YES – DATE _____ ☐ NO
COMPLETING A RESIDENTIAL OR DAY IN PATIENT PROGRAM IS A REQUIRMENT TO ATTEND SUPPORTIVE RECOVERY; WHICH PROGRAM HAS THE RESIDENT CLIENT COMPLETED?	
IS THE RESIDENT CLIENT **COMMITTED** TO COMPLETE A STRUCTURED, THERAPEUTIC POST RECOVERY PROGRAM? ☐ YES ☐ NO	DOES THE RESIDENT CLIENT EXPRESS A DESIRE (WILLINGNESS) FOR HIM/HER SELF TO CHANGE? ☐ YES ☐ NO
IS THE RESIDENT CLIENT WILLING TO BE INVOLVED IN ALL TYPES OF INTENSIVE COUNSELLING AND LIFE SKILLS DEVELOPMENT ACTIVITIES? ☐ YES ☐ NO	DOES THE RESIDENT CLIENT EXPRESS A NEED TO CHANGE HIS/HER LIFE SITUATION? ☐ YES ☐ NO
DOES THE RESIDENT CLIENT BELIEVE SOBRIETY IS NEEDED IN ORDER TO CHANGE? ☐ YES ☐ NO	DOES THE RESIDENT CLIENT ACCEPT AND UNDERSTAND THEY WILL BE IN A COMMUNAL LIVING ENVIRONMENT? ☐ YES ☐ NO
THE RESIDENT CLIENT UNDERSTANDS AND IS ABLE AND WILLING TO ADHERE TO RLTC PROGRAM AND RESIDENCE GUIDELINES? (SEE PART 11, PAGE 22) ☐ YES ☐ NO	IF YES, HAS THE RESIDENT CLIENT READ AND UNDERSTOOD RLTC PROGRAM AND RESIDENCE GUIDELINES? *DATE READ:* _____

[3] A copy of the Probation Order **MUST** be included with the Recovery Home Application before the application can be assessed.

RESIDENT CLIENT NAME	DATE OF BIRTH

WHAT ARE THE MAJOR PROBLEMS IN THE RESIDENT CLIENT'S LIFE SITUATION RELATED TO THE NEED THAT REQUIRES ADDITIONAL SUPPORT SERVICES?

PHYSICAL HEALTH	☐ YES	☐ NO	LEGAL	☐ YES	☐ NO
FAMILY/FRIENDS	☐ YES	☐ NO	LEISURE TIME	☐ YES	☐ NO
FINANCIAL	☐ YES	☐ NO	MENTAL HEALTH	☐ YES	☐ NO

FOR BASIC NEEDS (MANAGING HOUSING, FOOD, AND MONEY, ETC.)	☐ YES	☐ NO
CONTINUED AA OR NA OR OTHER SUPPORT GROUP ATTENDANCE	☐ YES	☐ NO
TO START OR CONTINUE IN CULTURAL/SPIRITUAL ACTIVITIES	☐ YES	☐ NO
OUTPATIENT/AFTERCARE COUNSELLING WITH A COUNSELLOR	☐ YES	☐ NO
EMPLOYMENT OR VOLUNTEER ACTIVITIES	☐ YES	☐ NO
LIFE SKILLS DEVELOPMENT	☐ YES	☐ NO

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

ARE THERE ANY FACTORS THAT WOULD INTERFERE WITH THE RESIDENCE CLIENT'S ATTENDANCE OR PARTICIPATION IN THE RLTC RECOVERY HOUSE PROGRAM?

(FAMILY, WORK, SCHOOL, MEDICAL, LEGAL, CHILDCARE, COURT APPEARANCE, ETC.) ☐ YES ☐ NO

IS THE RESIDENT CLIENT WILLING TO PARTICIPATE IN FIRST NATIONS PROGRAM COMPONENTS SUCH AS SWEAT LODGE, DAILY SMUDGE, PIPE AND OTHER CULTURAL CEREMONIES? ☐ YES ☐ NO

PRIOR TREATMENT PROGRAM AND/OR COUNSELLING

LIST ALL PREVIOUS TREATMENT CENTRES ATTENDED AND/OR COUNSELLING RECEIVED FOR ALCOHOL AND/OR DRUGS, EMOTIONAL PROBLEMS (ANGER, DEPRESSION, SUICIDE), FAMILY PROBLEMS (MARRIAGE/RELATIONSHIP), PROCESS ADDICTIONS (GAMBLING, SHOPPING), LIFE SKILLS DEVELOPMENT, LEGAL

INSTITUTION NAME	LOCATION	START DATE / END DATE	ISSUES WORKED ON	COMPLETED
1.				☐ YES ☐ NO
2.				☐ YES ☐ NO
3.				☐ YES ☐ NO
4.				☐ YES ☐ NO

SOCIAL SUPPORT SYSTEM

HAS THE RESIDENT CLIENT EVER ATTENDED:

ALCOHOLICS ANONYMOUS	☐ ATTENDED	☐ NOT ATTENDED	☐ WILLING TO ATTEND
NARCOTICS ANONYMOUS	☐ ATTENDED	☐ NOT ATTENDED	☐ WILLING TO ATTEND
12 STEP PROGRAM	☐ ATTENDED	☐ NOT ATTENDED	☐ WILLING TO ATTEND
WELLBERITY	☐ ATTENDED	☐ NOT ATTENDED	☐ WILLING TO ATTEND
OTHER _____	☐ ATTENDED	☐ NOT ATTENDED	☐ WILLING TO ATTEND

LIST ALL AFTERCARE SUPPORTS AVAILABLE IN THE COMMUNITY (I.E. 12 STEP MEETINGS, SUPPORT GROUPS, FAMILY/FRIENDS, FIRST NATIONS COMMUNITY, ELDERS)

RESIDENT CLIENT NAME	DATE OF BIRTH

WHAT HAS BEEN DISCUSSED WITH THE RESIDENT CLIENT REGARDING AFTERCARE PLANS AND COMING BACK INTO THE COMMUNITY AND HOME?

CURRENT DIAGNOSTIC STATUS

HAS THE RESIDENT CLIENT EVER BEEN PROFESSIONALLY ASSESSED BY A PSYCHOLOGIST OR PSYCHIATRIST? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DATES AND DETAILS **AND ATTACH A COPY OF THE ASSESSMENT**:

CHECK ALL APPLICABLE BOXES

☐ 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 ☐ FAS / FAE [4] ☐ SUICIDE IDEATION ☐ SUICIDE ATTEMPTS [5] ☐ SELF-HARM TENDENCIES

PLEASE PROVIDE BRIEF EXPLANATION

IS SUICIDE A CONCERN? ☐ YES ☐ NO IF YES, WHAT IS THE LEVEL OF RISK? _____

NOTE: INCLUDE HOSPITAL DISCHARGE SUMMARY REPORT FOR ANY SUICIDE ATTEMPTS WITHIN THE PAST YEAR. Resident Client must be deemed stable to reside in communal living environment with others.

REFERRAL WORKER / COUNSELLOR ASSESSMENT

IS THE RESIDENT CLIENT RECEIVING COUNSELLING FROM YOU? [6] ☐ YES ☐ NO

IF YES, HOW MANY POST-TREATMENT COUNSELLING SESSIONS HAS THE RESIDENT CLIENT ATTENDED? _____

HOW WAS THE RESIDENT CLIENT REFERRED TO YOU?	IS THE RESIDENT CLIENT RECEIVING OTHER COUNSELLING SERVICES? [7] ☐ YES ☐ NO IF YES, AGENCY NAME:

WHAT ISSUES HAS THE RESIDENT CLIENT WORKED ON IN HIS/HER SESSIONS?

WHAT IS YOUR PERCEPTION OF THE RESIDENT CLIENT'S READINESS FOR A POST TREATMENT PROGRAM?

CLIENT SNAP (STRENGTH, NEEDS, ABILITIES, PREFERENCES) (NOTE: THIS IS TO BE ANSWERED FROM THE RESIDENT CLIENT'S PERSPECTIVE)

WHAT DOES THE RESIDENT CLIENT BELIEVE ARE HIS/HER:

STRENGTHS (ASSETS, RESOURCES): _____

NEEDS (LIABILITIES, WEAKNESSES): _____

ABILITIES (SKILLS, APTITUDES, CAPABILITIES, TALENTS, COMPETENCIES): _____

PREFERENCES (THOSE THINGS THE RESIDENT CLIENT THINKS, FEELS WILL ENHANCE HIS/HER POST RECOVERY EXPERIENCE): _____

IN THE RESIDENT CLIENT'S OWN WORDS, WHAT ARE THEIR PRESENTING PROBLEMS AND CHALLENGES? _____

[4] If FAS/FAE please provide results along with the date of testing.
[5] Provide details such as date, whether Resident Client was hospitalized and for how long, how attempt was made, is the Resident Client stable?
[6] Resident Client must have completed a residential or day treatment program to participate in supportive recovery home.
[7] If YES, **ALL** Counsellors are required to complete and submit this portion of the application package.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 5 – CLIENT SCREENING

ALCOHOL / DRUG HISTORY

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**	**HOW OFTEN USED** (DAILY / WEEKLY / MONTHLY)	**AMOUNT/QUANTITY**	**METHOD OF USE** (INJECT / SMOKE / INGEST / SNORT)	**DATE LAST USED** (MONTH / DAY / YEAR)
ALCOHOL (BEER, WINE, HARD LIQUOR)					
CANNABIS (POT, HASH)					
COCAINE (CRACK, COKE)					
HALLUCINOGEN (ACID, MUSHROOMS, PCP, KETAMINE)					
BARBITURATE (PHENNIES, YELLOW JACKETS)					
AMPHETAMINE (***CRYSTAL METH, ECSTASY, SPEED)					
HEROIN (CHINA WHITE, CRANK)					
OPIATE (MORPHINE, CODEINE, OPIUM)					
INHALANT (GLUE, HAIRSPRAY)					
ILLICIT METHADOSE					
BENZODIAZEPINE (SLEEPING PILLS, TRANQUILIZERS)					
OVER THE COUNTER DRUGS (COUGH SYRUP)					
OTHER PRESCRIPTION DRUGS (T3s, VALIUM)					
TOBACCO					
OTHER					

IMPORTANT NOTE: ADMISSION CRITERIA: RESIDENT CLIENT MUST HAVE COMPLETED A TREATMENT PROGRAM PRIOR TO ADMISSION. **NO EXCEPTIONS.** CLIENTS MAY BE DRUG TESTED UPON ADMISSION.

***CRYSTAL METH USE CLEAN TIME IS FIVE (5) MONTHS ABSTINENCE. NO EXCEPTIONS.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 5 – CLIENT SCREENING – Complete ONLY if Applicant is an External Referral

PLEASE PRINT CLEARLY

ALCOHOL SCREENING TEST

THE FOLLOWING QUESTIONS ARE ABOUT YOUR ALCOHOL USE DURING THE PAST 12 MONTHS (CIRCLE YOUR RESPONSE)

DO YOU FEEL THAT YOU ARE A NORMAL DRINKER?	YES (0) NO (2)	DO FRIENDS OR RELATIVES THINK YOU ARE A NORMAL DRINKER?	YES (0) NO (2)
HAVE YOU ATTENDED A MEETING OF ALCOHOLICS ANONYMOUS (AA)?	YES (5) NO (0)	HAVE YOU LOST FRIENDS OR GIRLFRIENDS/BOYFRIENDS BECAUSE OF YOUR DRINKING?	YES (2) NO (0)
HAVE YOU GOTTEN INTO TROUBLE AT WORK BECAUSE OF YOUR DRINKING?	YES (2) NO (0)	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)
HAVE YOU HAD DELIRIUM TREMENS (DTs), SEVERE SHAKING, HEARD VOICES OR SEEN THINGS THAT WERE NOT THERE AFTER HEAVY DRINKING?	YES (2) NO (0)	HAVE YOU GONE TO ANYONE FOR HELP ABOUT YOUR DRINKING?	YES (5) NO (0)
HAVE YOU BEEN IN A HOSPITAL BECAUSE OF DRINKING?	YES (5) NO (0)	HAVE YOU RECEIVED A 24-HOUR ROADSIDE SUSPENSION OR HAVE YOU BEEN CHARGED FOR IMPAIRED DRIVING?	YES (2) NO (0)
TOTAL SCORES MAY RANGE FROM 0 TO 29. (SCORES OF 6 OR GREATER ARE CONSIDERED TO REFLECT SERIOUS PROBLEMS WITH ALCOHOL).		**TOTAL SCORE:**	

DRUG SCREENING TEST

THE FOLLOWING QUESTIONS CONCERN INFORMATION ABOUT YOUR POTENTIAL INVOLVEMENT WITH DRUGS **NOT INCLUDING ALCOHOLIC BEVERAGES** DURING THE PAST 12 MONTHS

HAVE YOU USED DRUGS OTHER THAN THOSE REQUIRED FOR MEDICAL REASONS?	YES (1) NO (0)	HAVE YOU ABUSED PRESCRIPTION DRUGS?	YES (1) NO (0)
DO YOU ABUSE MORE THAN ONE DRUG AT A TIME?	YES (1) NO (0)	CAN YOU GET THROUGH THE WEEK WITHOUT USING DRUGS?	YES (0) NO (1)
ARE YOU ALWAYS ABLE TO STOP USING DRUGS WHEN YOU WANT TO?	YES (0) NO (1)	HAVE YOU HAD BLACKOUTS OR FLASHBACKS AS A RESULT OF DRUG USE?	YES (1) NO (0)
DO YOU EVER FEEL BAD OR GUILTY ABOUT YOUR DRUG USE?	YES (1) NO (0)	DOES YOUR SPOUSE (OR PARENTS) EVER COMPLAIN ABOUT YOUR INVOLVEMENT WITH DRUGS?	YES (1) NO (0)
HAS DRUG ABUSE CREATED PROBLEMS BETWEEN YOU AND YOUR SPOUSE OR YOUR PARENTS?	YES (1) NO (0)	HAVE YOU LOST FRIENDS BECAUSE OF YOUR USE OF DRUGS?	YES (1) NO (0)
HAVE YOU NEGLECTED YOUR FAMILY BECAUSE OF YOUR USE OF DRUGS?	YES (1) NO (0)	HAVE YOU BEEN IN TROUBLE AT WORK BECAUSE OF DRUG ABUSE?	YES (1) NO (0)
HAVE YOU LOST A JOB BECAUSE OF DRUG USE?	YES (1) NO (0)	HAVE YOU GOTTEN INTO FIGHTS WHEN UNDER THE INFLUENCE OF DRUGS?	YES (1) NO (0)
HAVE YOU ENGAGED IN ILLEGAL ACTIVITIES IN ORDER TO OBTAIN DRUGS?	YES (1) NO (0)	HAVE YOU BEEN ARRESTED FOR POSSESSION OF ILLEGAL DRUGS?	YES (1) NO (0)
HAVE YOU EVER EXPERIENCED WITHDRAWAL SYMPTOMS (FELT SICK) WHEN YOU STOPPED USING DRUGS?	YES (1) NO (0)	HAVE YOU HAD MEDICAL PROBLEMS AS A RESULT OF YOUR DRUG USE (E.G. MEMORY LOSS, HEPATITIS, CONVULSIONS, BLEEDING)?	YES (1) NO (0)
HAVE YOU GONE TO ANYONE FOR HELP FOR DRUG PROBLEMS?	YES (1) NO (0)	HAVE YOU BEEN INVOLVED IN A TREATMENT PROGRAM SPECIFICALLY RELATED TO DRUG USE?	YES (1) NO (0)
SCORE: **0** NO PROBLEM **1 – 5** LOW **6 – 10** MODERATE **11 – 15** SUBSTANTIAL LEVEL **16 – 20** SEVERE LEVEL		**TOTAL SCORE:**	

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 7 – PHYSICIAN or NURSE PRACTITIONER'S REPORT (To be completed by Client's Physician or Nurse Practitioner)

SURNAME (LEGAL)	FIRST NAME	MIDDLE NAME

CARE CARD NUMBER	STATUS NUMBER

INFORMED CONSENT MUST BE COMPLETED WITH PATIENT

I, (RESIDENT CLIENT'S NAME) _____ HEREBY REQUEST AND GIVE PERMISSION TO _____ TO RELEASE MY MEDICAL INFORMATION TO ROUND LAKE TREATMENT CENTRE AND MY REFERRAL WORKER. I ALSO CONSENT TO HAVE THE ROUND LAKE TREATMENT CENTRE NURSE, COUNSELLOR OR TREATMENT STAFF CONSULT OR INQUIRE WITH MY ABOVE NAMED HEALTH CARE PROVIDER ON ANY OF MY MEDICAL NEEDS WHILE IN TREATMENT.

_____ _____

RESIDENT CLIENT SIGNATURE DATE

FUNCTIONAL INQUIRY AND PHYSICAL EXAM

ALLERGIES (INCLUDING DIETARY) ☐ YES ☐ NO IF YES, PLEASE SPECIFY _____

NOTE: PATIENT MUST HAVE EPI-PEN OR ANA-KIT IF ALLERGIC TO BEES OR NUTS. (SPECIFY DIETARY ALLERGIES)

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 PREGNANCIES? [8]		
SKIN	INFESTATIONS:	INFECTIONS:		
STDs ☐ YES ☐ NO	NEG	POS	TYPE:	
HEP C ☐ YES ☐ NO	NEG	POS		
HIV / AIDS TEST? ☐ YES ☐ NO	NEG	POS		

[8] For Pregnant Client: 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.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 7 – PHYSICIAN or NURSE PRACTITIONER'S REPORT (To be completed by Client's Physician or Nurse Practitioner)

IS THIS PATIENT ON ANY MEDICATIONS? ☐ YES ☐ NO **(PLEASE GIVE AN ACCURATE PRE-ADMISSION MEDICATION LIST NOW AND 14 DAYS PRIOR TO INTAKE)**

PRINT NAME OF MEDICATION(S)	AMOUNT	FREQUENCY	REASON
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

YOUR CLIENT'S MEDICATIONS ARE REQUIRED TO BE BLISTER PACKED ON A WEEKLY BASIS. **NOTE: AFTER RECEIVING CONFIRMATION OF YOUR CLIENT'S ACCEPTANCE TO RLTC, IT IS MANDATORY THE CLIENT'S PHYSICIAN or NURSE PRACTITIONER FAXES THE ORIGINAL PRESCRIPTION(S) TO HOGARTH'S PHARMACY (FAX: 250-545-4392). NO EXCEPTIONS.**

- PLEASE LIST ADMISSION DIAGNOSIS WITH A BRIEF HISTORY OF PRESENT ACTIVE MEDICAL CONDITIONS.
- PROVISIONS FOR ANY FOLLOW-UP TREATMENTS OR CARE REQUIRED WHILE IN TREATMENT AT RLTC? PLEASE SPECIFY.
- ANY PERTINENT PHYSICAL EXAMINATION FINDINGS? PLEASE SPECIFY.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 7 – PHYSICIAN or NURSE PRACTITIONER'S REPORT (To be completed by Client's Physician or Nurse Practitioner)

IS PATIENT DUAL DIAGNOSIS? FOR EXAMPLE, BIPOLAR, PTSD, SCHIZOPHRENIA, FASD, ADHD ☐ YES ☐ NO

- LENGTH OF MENTAL STABILITY? CURRENT COGNITIVE STATUS?
- ABILITY TO PARTICIPATE IN GROUP THERAPY FOR EIGHT HOURS A DAY?
- WHO PROVIDED THE DIAGNOSIS AND IS CLIENT PRESENTLY IN TREATMENT WITH THIS DOCTOR/PSYCHOLOGIST? PLEASE PROVIDE A WRITTEN SUMMARY OF CLIENT'S THERAPY PLAN.
- IS THE DIAGNOSING DOCTOR IN AGREEMENT WITH A/D TREATMENT?

AS A PRE-REQUISITE TO RESIDENTIAL POST RECOVERY SUPPORT SERVICES , THE PATIENT MUST:

- BE FREE FROM ALL COMMUNICABLE DISEASES (I.E. SCABIES, LICE) ☐ YES ☐ NO
- HAVE A TB TEST IN THE LAST 12 MONTHS (**ATTACH RESULTS**) ☐ 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.
- **HAVE COMPLETED STAGE II TREATMENT DEFINED AS: INDIVIDUALS WHO HAVE COMPLETED SOME TYPE OF RECOVERY BASED PROGRAM AND ARE STABILIZED**

PHYSICIAN / NURSE PRACTITIONER NAME	**OFFICE STAMP**
ADDRESS	
CITY	
PROVINCE	
POSTAL CODE	
TELEPHONE	
FAX	
_____ PHYSICIAN / NURSE PRACTITIONER SIGNATURE	_____ DATE

Note: Please ensure you have read and reviewed **PART 8 – Safe/Unsafe Medications List – Updated: July 4, 2016** on page 13, as non-compliance with said list will result in the Resident Client not being accepted.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 8 – SAFE / UNSAFE MEDICATION LIST – Updated: July 4, 2016 PHYSICIAN'S REPORT

The following list is for common and prescription medications, which are Safe / Unsafe for use for persons in recovery. If a medication changes the way you feel or is mood altering, **AVOID IT.**

NOTE: Ensure generic medications fall into the Safe category of acceptable medications.

UNSAFE	SAFE
Avoid pain medications that contain Opiates (e.g. Codeine): • Tylenol 1, 2, 3 or 4 (all Opioids) • Demerol • Percocet • Fiorinal Plan ¼ or ½ • Levo-Dromoran • 222, 282, 292, 692, Darvon (Propoxyphene) • Talwin • Percodan • Leritine • Dilaudid • Nabilone **Avoid Nerve and Sleeping Pills including:** • Librium • Tranxene • Serax • Xanax • Others used for anxiety/nervousness/ tranquilizer • All Benzodiazepines **Avoid CNS Stimulants such as Methamphetamines:** • Dextroamphetamine (Dexedrine) • Lisdexamphetamine **Avoid Sleeping Pills including these and others:** • Dalmane • Halcion • Restoril • Tuinal • Seconal • Zopiclone (Imovane) **Avoid Muscle Relaxants:** • Robaxisal • Robaxacet • Parafon • Flexeril **Over the Counter Medications can be a Serious Threat:** • Cough syrups contain alcohol, codeine and antihistamines. These are all drugs which need to be avoided. **Avoid Sedating Antihistamines such as:** • Gravol • Actifed • Dimetap • Chlortriplon • Benydryl or products containing diphenhydramine	**Pain Medications:** • Regular or Extra Strength Tylenol • ASA or Aspirin • Advil or Ibuprofen • Midol **Available Only by Prescription:** • Tryptan • Buspirone (Buspar) • Gabapentin • Toradol • Possible other prescription medications – please contact Resident Nurse for clarification **Antidepressants Safe with Proper Use and by Prescription Only:** • Elavil • Citalopram • Morex • Serzone • Desipramine • Effexor (Venlafaxine) • Zoloft (Sertraline) • Prozac (Fluoxetine) • Luvox (Fluvoxamine) • Paxil (Paroxetine) • Trazodone (Desyrel) • Mirtazapine • Buproprion • Seroquel (Quetiapine) **Migraines:** • Imitrex **Non-Sedating Antihistamines:** • Seldane • Claritin • Hismanil **Sleep Aids:** • Epsom Salt • Melatonin • Calcium (333mg) Magnesium (167mg) with VD3 (5mcg) • Lavender Oil

Note: This is a partial list. If you require more information, please ask the Doctor or Pharmacist about non-psycho active/mood-altering medications.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 9 – METHADONE HARM REDUCTION TREATMENT

To refer an applicant on methadone to the Methadone Maintenance Program at RLTC, you must contact the Intake Coordinator to ensure your client meets the following requirements.

1. The applicant requirements include:
   A history of having been **stabilized** on methadone for **4 weeks within a daily therapeutic dose of 60mg-100mg, not to exceed 170mg. This means the dosage of methadone has not been in the process of upward titration in the last 4 weeks.**

   - **Stabilization** would be when a person is not experiencing withdrawal symptoms or cravings (occurs when under medicated) or drowsiness (nodding) or constriction of pupils (occurs when over medicated).
   - **Be abstinent free for 2 weeks** from alcohol, illicit drugs, medical marijuana and medications listed on our unsafe list.
   - **Proof of 2 clean urines** prior to coming to RLTC, from your prescribing physician's office. One clean urine per week for the 2 weeks PRIOR to attending RLTC. **Please fax results to RLTC at 250-546-3227, attention Resident Nurse.**

2. The applicant may be required to have a methadone "carry" dose to arrive at RLTC and return to their home community, as it will be dependent on the amount of travel time, to and from RLTC **in a mandatory lock box.**

3. Methadone will be supplied by Hogarth's Pharmacy on the Monday or Tuesday of intake and weekly until discharge.

4. Only after receiving confirmation of the applicant's admission to RLTC, it is **mandatory** that the applicant's methadone prescribing physician **faxes the original prescription to: Hogarth's Pharmacy (250-545-4392)**

5. Prior to admission, the applicant will sign the Methadone Maintenance Program Contract with the methadone prescribing physician.

6. It is imperative that *the applicant be aware of the mandatory two clean urines* over two weeks prior to coming to Round Lake.

7. It is imperative that *the applicant be aware of the mandatory supervised urine samples* that may be requested for drug screening upon admission or if deemed necessary.

8. *The applicant understands that methadone is a witnessed dose*, under supported self-administration, by the resident nurse or other qualified personnel in the nurse's office. ***Client's methadone dosage will not be altered while in treatment*.**

9. Prior to admission, all applicants must have evidence that they are free of TB. (A Tuberculosis Skin Test can be done at any Public Health Unit.) Please arrange this as soon as you refer the applicant. **Note: If the Tuberculosis Skin Test is positive, a chest x-ray must be arranged and results of the x-ray may take up to 6 weeks.**

We hope this is all the information you and your Resident Client require. If not, please feel free to phone the Intake Coordinator if you have any further questions.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 9 – METHADONE HARM REDUCTION TREATMENT **PLEASE PRINT CLEARLY**

METHADONE MAINTENANCE PROGRAM CONTRACT

This contract shall be between _____ (Applicant) and the Round Lake Treatment Centre.

My start date on methadone was _____ at a current therapeutic dosage of _____, meeting the 4 week stabilization required by Round Lake Treatment Centre. **This means the dosage of methadone has not been in the process of upward titration in the last 4 weeks.**

My prescribing physician is Dr. _____ of _____

Phone Number _____ Fax # _____.

Please initial all boxes as acknowledgement of the contract guidelines

- ☐ I acknowledge that I come to RLTC **stabilized** on a methadone program.
- ☐ I acknowledge that I have **two weeks abstinence** from alcohol, illicit drugs, medical marijuana, and medications from the unsafe list.
- ☐ I acknowledge that I have an opioid use disorder and wish to continue my methadone program while at the Round Lake Treatment Centre.
- ☐ I agree that while at RLTC, I will receive my methadone daily from the resident nurse or a qualified designate.
- ☐ The methadone maintenance program at RLTC is based on the Protocols from the BC Centre on Substance use (BCCSU).
- ☐ I agree to adhere to the program guidelines as detailed to me upon orientation to the facility.
- ☐ I understand that my failure to participate in the program as outlined will result in a review of my suitability stabilization for the treatment program.
- ☐ I **agree to a supervised urine sample for drug screening as requested**. I understand that failure to comply will result in termination from the program.
- ☐ I will swallow my methadone, witnessed, as according to the protocols.

Physician to witness the proceeding,

_____ _____

PHYSICIAN SIGNATURE DATE

_____ _____

CLIENT SIGNATURE DATE

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 10 – SUBOXONE MAINTENANCE PROGRAM

To refer an applicant to the Suboxone Maintenance Program at RLTC, you must phone/contact the Intake Coordinator to ensure your client meets the following requirements.

1. The applicant requirements include:
   - A history of having been **stabilized** on suboxone for **2 weeks**; within a daily therapeutic dosage **not to exceed 24 mg.**
   - **Stabilization** would be when a person is not experiencing withdrawal symptoms or cravings (occurs when under medicated) or drowsiness (nodding) or constriction of pupils (occurs when over medicated).
   - **Be abstinent free for 2 weeks** from alcohol, illicit drugs, medical marijuana and medications listed on our unsafe list.
   - **Proof of 2 clean urines** prior to coming to RLTC, from your prescribing physician's office. One clean urine per week for the 2 weeks prior to attending RLTC.

     Please fax to RLTC, (250) 546-3227 attention resident nurse.

2. The client may be eligible to have a Suboxone "carry" dose to arrive at RLTC and return to their home community at the discretion of their prescribing physician, as it will be dependent on the amount of travel time to and from RLTC**, in a mandatory lock box.**

3. Suboxone will be supplied by the Hogarth's Pharmacy on the Monday or Tuesday of intake, and weekly until discharge.

4. **Upon receiving confirmation** of the applicants admission to RLTC, it is mandatory that the applicant's suboxone prescribing physician,

   Fax original prescription to:

   Hogarth's Pharmacy in Vernon, BC fax# (250) 545- 4392

5. Prior to admission the applicant will complete and sign the **Suboxone Maintenance Program Contract** with the suboxone prescribing physician.

6. It is imperative that *the applicant be aware of the mandatory two clean urines* over two weeks prior to coming to Round Lake.

7. It is imperative that *the applicant be aware of the mandatory supervised urine samples* that may be requested for drug screening upon admission or if deemed necessary.

8. *The applicant understands that suboxone is a witnessed dose*, under supported self-administration, by the resident nurse or other qualified personnel in the nurse's office. ***Client's Suboxone dosage will not be altered while in treatment*.**

9. Prior to admission all clients must have evidence that they are free of TB. (A Tuberculosis Skin Test can be done at any Public Health Unit.) Please arrange this as soon as you refer the client. **Note: If the Tuberculosis Skin Test is positive a Chest x-ray must be arranged and results of the x-ray may take up to 6 weeks.**

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 10 – SUBOXONE MAINTENANCE PROGRAM (Continued) **PLEASE PRINT CLEARLY**

SUBOXONE MAINTENANCE PROGRAM CONTRACT

(To be completed with methadone prescribing physician and applicant)

This contract shall be between _____ (Applicant) and the Round Lake Treatment Centre**.**

My start date on Suboxone was _____ at a current therapeutic dosage of _____, meeting the 2 week stabilization required by Round Lake Treatment Centre. **This means the dosage of Suboxone has not been in the process of upward titration in the last 2 weeks.**

My prescribing physician is Dr. _____ of _____

Phone Number _____ Fax # _____.

Please initial all boxes as acknowledgement of the contract guidelines

- ☐ I acknowledge that I come to RLTC **stabilized** on a suboxone program.
- ☐ I acknowledge that I have **two weeks abstinence** from alcohol, illicit drugs, medical marijuana, and medications from the unsafe list.
- ☐ I acknowledge that I have an opioid use disorder and wish to continue my suboxone program while at the Round Lake Treatment Centre.
- ☐ I agree that while at RLTC, I will receive my suboxone daily from the resident nurse or a qualified designate.
- ☐ I agree to adhere to the program guidelines as detailed to me upon orientation to the facility.
- ☐ I understand that my failure to participate in the program as outlined will result in a review of my suitability stabilization for the treatment program.
- ☐ I **agree to a supervised urine sample for drug screening as requested**. I understand that failure to comply will result in termination from the program.
- ☐ I will dissolve, sublingually, my suboxone, witnessed, as according to the protocols.

Physician to witness the proceeding,

PHYSICIAN SIGNATURE DATE

CLIENT SIGNATURE DATE

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 11 – FORMS **PLEASE PRINT CLEARLY**

CONSENT TO ATTEND AND PARTICIPATE IN POST RECOVERY TREATMENT

I, (Please Print Resident Client's Name) _____ consent to attend and participate at RLTC and I have reviewed the following points with my Referral Worker and initialed as confirmation of my understanding of the following points.

1. I must have completed a recovery based treatment program and am behaviorally capable of residing in a communal living environment with others.
2. I understand an incomplete application and lack of supporting documentation delays the processing of my application and confirmation of an intake date.
3. I consent to the Intake Coordinator / Nurse, contacting referral agencies, such as Probation Officers, Medical Practitioners, etc., to obtain clarification on information included in this application. If on Income Assistance, I agree the Intake Coordinator can release confirmation of my intake and discharge dates to my Employment and Assistance Worker and First Nations Health.
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 listed and dealt with PRIOR to admission to RLTC. All legal issues will be reviewed on a case-by-case basis by RLTC.
5. I understand the Intake Coordinator will notify my referral worker by letter to confirm my acceptance in the supportive Recovery Home.
6. While in-residence, 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 Recovery 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 Supportive Recovery Home 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. If accepted, I consent for the Clinical Counsellor to confer with my probation officer, if applicable, regarding my progress and clarifying any details.
11. I, (Please Print Resident Client's Name) _____ hereby give permission for RLTC staff to contact the referral worker(s) listed below for the release of information in regard to a pre-admission conference call and progress during Post Treatment and Final Discharge Report.

REFERRAL WORKER'S NAME		TITLE
ORGANIZATION / AGENCY NAME		NNADAP WORKER ☐ YES ☐ NO
ADDRESS		
CITY	PROVINCE	POSTAL CODE
TELEPHONE	FAX	EMAIL
ALTERNATE CONTACT PERSON		

RESIDENT CLIENT SIGNATURE DATE

REFERRAL WORKER SIGNATURE DATE

NOTE: 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 POST RECOVERY PROGRAM. The Resident Client may change or revoke this release at any time by giving notice to Round Lake Treatment Centre in writing. It is up to the Resident Client to inform their referral worker of the change. **This form is applicable for one year after the date signed unless revoked.**

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 11 – FORMS **PLEASE PRINT CLEARLY**

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (Resident Client's name) hereby give permission for Round Lake Treatment Centre staff to:

- ☐ Fax the Ministry of Employment and Income Assistance the confirmation dates that I have will be in residence in a Supportive Recovery Home and completion date for the purposes to arrange travel.
- ☐ Fax/Phone Probation Officer dates that I am in residence regarding my arrival and discharge dates.
- ☐ Confirm attendance and discharge dates with my employer or insurance company for the purpose of receiving weekly indemnity benefits/short-term disability from employer.
- ☐ Fax/Phone Band office my attendance at Round Lake Recovery Home for making travel arrangements.

I, _____ (Resident Client's name) hereby give permission for Round Lake Treatment Centre staff to be in contact with the person listed below to assist with my travel needs:

SURNAME (LEGAL)	FIRST NAME	MIDDLE NAME
ADDRESS	CITY, PROVINCE	POSTAL CODE
TELEPHONE	CELL	EMAIL

The release of information is applicable only for the above-noted purpose.

_____ _____

RESIDENT CLIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

NOTE: *The Resident Client may change or revoke this release at any time by giving written notice to Round Lake Treatment Centre. It is up to the Resident Client to inform their Counsellor (Nurse) of the change. This form is applicable for the duration of the Resident Client's stay or 6 months after the date signed unless revoked by the Resident Client in writing.*

RESIDENT CLIENT NAME	DATE OF BIRTH

RETURN ASSURANCE TRAVEL FORM

PLEASE PRINT CLEARLY

(NOTE: ***If the Resident Client is discharged or voluntarily leaves Supportive Recovery Home before completion, Social Assistance and First Nations Inuit Health Branch will NOT cover return travel.)***

This form is to be filled out by the person responsible for the return travel costs for the Resident 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 limited to place of residence incurred by _____ (Resident Client's Name). I understand that if the Resident Client is discharged or voluntarily leaves treatment before completion that Social Assistance and First Nations Health Authority will not cover return travel.

In the case that Round Lake Treatment Centre must pay for any of the Resident 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 costs incurred by RLTC to get the above named Resident Client safely home.

Note: Any outstanding debts incurred by the above noted Resident Client will prevent all future intake processing until it is paid in full.

SURNAME (LEGAL)	FIRST NAME	MIDDLE NAME
ADDRESS	CITY, PROVINCE	POSTAL CODE
TELEPHONE	CELL	EMAIL

_____ _____

SIGNATURE DATE

METHOD OF PAYMENT

To be eligible for the Post Treatment Support Services, residents must be willing to contribute to food and shelter costs.

- Each Resident must pay shelter costs of $400 per month and a $265 damage deposit.
- Full payment of first month's rent and damage deposit must be paid prior to admission.
- Shelter costs are to be paid at the first of the month for each month of residency The Resident's file will reflect a proof of payment.

PLEASE PRINT CLEARLY

INCOME ASSISTANCE	☐ YES ☐ NO	ELIGIBLE FOR INCOME ASSISTANCE	☐ YES ☐ NO
OTHER, PLEASE DESCRIBE	☐ YES ☐ NO	OUTSTANDING ISSUES PREVENTING FUNDING? IF YES, PLEASE DESCRIBE:	☐ YES ☐ NO

RESIDENT CLIENT NAME	DATE OF BIRTH

REFERRAL WORKER REQUEST TO FAX OR EMAIL RESIDENT 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 Resident Client Confirmation of Intake letter faxed or emailed to my place of business for:

   _____ _____
   RESIDENT CLIENT NAME DATE OF BIRTH

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 Resident Client of the decision to have the Confirmation of Intake letter faxed or emailed with the understanding that the place or time the letter is being faxed or emailed may not secure confidentiality.

4. I understand that no Resident Client information will be faxed or emailed 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 _____, 2016

_____ _____
REFERRAL WORKER SIGNATURE RESIDENT CLIENT NAME

_____ _____
WORK TITLE AND AGENCY NAME RESIDENT CLIENT SIGNATURE

NOTE: *The Resident Client may change or revoke this release at any time by giving written notice to Round Lake Treatment Centre. It is up to the Client to inform their Counsellor (Nurse) of the change. This form is applicable for the duration of the Resident Client's stay or 6 months after the date signed unless revoked by the client in writing.*

RESIDENT CLIENT NAME	DATE OF BIRTH

CONFIRMATION OF FUNDING PAID THROUGH THE MINISTRY OF EMPLOYMENT AND INCOME ASSISTANCE

Dear Employment and Income Assistance Worker:

We are requesting a confirmation of funding for Resident Client Shelter Contribution of **$400 per month** for your Client who is scheduled to enter Post Treatment Supportive Recovery Services at the Round Lake Treatment Centre. This letter is to confirm that the Client's Post Treatment Services is to be subsidized by the Ministry, does in fact have an active file in the system and has made proper arrangements. A damage deposit of $265 is due at the first of the month of admission.

Payment can be mailed to: Round Lake Treatment Centre, 200 Emery Louis Road, Armstrong, BC V0E 1B5. Be sure to include Round Lake's name on the Address.

TRAVEL: Return bus and/or taxi fares are to be included. Taxi cheques may be payable to Vernon Taxi (260 – 3103 A – 31st Avenue, Vernon, BC V1T 3M1 and Telephone: 250-545-3337) in the amount of $60.00 per trip.

Complete the following and return a copy to Round Lake Treatment Centre for our records and provide a copy to the Client as he/she is required to return this to their referral worker. You can fax to us at 250-546-3227 or scan and email to: intake@roundlake.bc.ca

RESIDENT CLIENT TO COMPLETE:

I give my permission to the personnel of Round Lake Treatment Centre to release information about my intake and discharge dates to my Employment and Income Assistance Worker.

SIGNED THIS _____ day of _____, 2017

RESIDENT CLIENT SIGNATURE	RESIDENT CLIENT SOCIAL INSURANCE NUMBER
PRINT RESIDENT CLIENT NAME	
EMPLOYMENT AND INCOME ASSISTANCE WORKER	CONTACT TELEPHONE NUMBER
OFFICE CODE	DATE OF PER DIEM CONFIRMATION
MAILING DATE OF COMFORT ALLOWANCE	TREATMENT INTAKE AND DISCHARGE DATES

PART 12 – ROUND LAKE TREATMENT CENTRE RECOVERY HOME GUIDELINES

Round Lake has designed a set of Program Guidelines that reflect respect, consideration, and self-responsibility. Round Lake considers these to be three very essential components for recovery and self-empowerment. The guidelines ensure your physical, mental, emotional and spiritual safety to allow you the freedom to participate fully in the program in a safe and supportive environment. – **Please read these guidelines carefully and be prepared to follow them for the safety of all people.**

All Residents are expected to be actively engaged in all areas of the program as this will increase the chances of remaining substance-free, foster heightened sense of connection/ belonging and the development of holistic well-being.

This includes, but is not limited to:

- Remaining substance free
- Willing to engage and commit to and in the development of your individualized service care plan
- Participate in mandatory programming as required
- Access appropriate resource for physical and/or mental health care
- Participate in individual and group counselling
- Address your financial, legal and self-care and daily living needs as outlined with your Clinical Counsellor

Alcohol and Drugs

- Round Lake Treatment Centre has zero tolerance on the possession or use of alcohol or non-prescribed drugs by residents on the property of Round Lake Treatment Centre and may result in immediate dismissal from the recovery home.
- A personal baggage check will be conducted upon initial entry into the Post Recovery Program. Subsequent baggage or room checks will be conducted wherein there is suspicion of non-compliance to resident guidelines.
- Resident Clients may also be asked to submit to a urine test upon entry and / or when returning from time away from the Recovery Home.

Phone calls

- Phone calls are to be made outside of Program times. No cell phone usage is permitted during group activities with Pre-treatment clients or clients currently participating in the Stage II Recovery program. You will not be called from session for personal calls. However, in the event of an emergency, your counsellor will inform you immediately. Personal messages are posted at the Recovery Home office or on the bulletin board at the residence.
- **Checking for mail:** Monday to Friday, check for mail after 4:00 pm at the Recovery Home office or Life Skills Worker (LSW) office.

Health and Safety

- ABSOLUTELY no smoking in any of the buildings. Smoke only permitted in the designated smoking areas, utilizing ashtrays for disposal and extinguishment. This guideline includes all smokeless, chewing tobacco products. Smoking areas are to be well maintained and kept clean by those who utilize it.
- Please ask a staff person for assistance if you wish to smudge your sleeping area
- All medication will be turned in to the Life Skills Worker (LSW) at intake. You will be given access to your medication by the Nurse or LSW. All medications brought into or obtained during your stay will be monitored. You will self-administer all your medications which will be recorded on the individual resident medical form. The Resident Nurse will review and record all current resident prescriptions as required.

Other

- A high standard of personal hygiene is required. Appropriate dress code required, i.e. shirts worn at all times, day wear clothing is a must in common areas; modest attire is an expectation in your recovery. Staff will assist you to address this area if it is an area of concern.
- Laundry facilities are available for your use.
- Resident conduct is expected to be respectful and mindful of all in residence. Communal living requires cooperation and communication, consideration of others and a willingness to work together. Common areas are provided for the use of all in residence.
- Daily upkeep of your assigned room is a personal responsibility and a must. Sleeping areas are private quarters.
- No visiting in another resident's room or inviting others into your room is permitted.
- No unsupervised group/circle work at any time. No "counselling" of other residents.
- If you have your own vehicle, you are expected to take responsibility for asserting your boundaries/limits with others as needed.

- Clients are not to sell items to each other or to staff.
- **Personal bedding, including blankets, pillows, cushions, and stuffies are NOT permitted.**
- Clients in RLTC's regular residential treatment are not permitted in the Recovery home setting

Visitors

- Visitors are not allowed at the Recovery Home residence until a full month of stay is completed.
- Preferred arrangement for visits and visitors are to be made off-site in the community.
- Visiting hours are from 1:00 p.m. to 4:30 p.m. Saturdays and Sundays and must sign a visitor confidentiality agreement form on FIRST visit.
- Visits must occur in common areas of the residence. This ensures the anonymity of the other residents and the safety of all.
- No visitors are permitted in the individual resident rooms.
- Visitors under the influence of alcohol or drugs are prohibited from the Centre grounds. Round Lake Treatment Centre is committed to providing an alcohol-and-drug-free environment for the residents, staff and visitors.
- Any children (child to mean anyone under 16 years of age) visiting must be accompanied and supervised by an adult (other than the resident) at all times. We would encourage all visitations with children off site if possible.

Communal Living Essentials

- Actively participate in assigned household chores and group activity.
- Assist in keeping all areas of use, common areas clean, tidy and well maintained.
- Respectful regard for each other and of differences, diversity, differing levels of an individual's stage in recovery.
- Hours of curfew will ensure adequate rest is a part of daily routine.
- Respectful utilization of recovery skills learned to resolve conflict and/or problem solve.
- Encourage support and play in the resident group when appropriate.

Resident Discharge

Withdrawal/dismissal from the program requires prompt exit from the premises. You will be asked to wait at the Administration building while waiting for taxi, etc., as the program requires prompt exit from the premises.

RESIDENT DISCHARGE will occur when a resident:

- Has willfully caused injury to another person. This includes acts of violence toward other residents, and/or staff such as physical, excessive verbal or emotional abuse, threats, intimidation or acts of sexism, racism or harassment.
- Are in possession of, or used alcohol at the facility.
- Has become involved in an intimate relationship with another resident and is ***unwilling*** to stop the relationship.
- Non-compliance with prescribed medication.
- Non-compliance with Round Lake Treatment Centre guidelines or programming.

Discharge or Completion from the Program

Residents who have completed the supportive recovery program or voluntarily leave or are discharged from the program are to be mindful and considerate of ongoing contact with residents still in session. Positive ongoing support must be in alignment with your peer's long term recovery objectives, must be consensual and must not be an interference or distraction. Consequently, Round Lake may intercept any incoming mail, email or calls from past residents or any person attempting to interfere or potentially derail another's program.

RESIDENT CLIENT NAME	DATE OF BIRTH

PART 13 – GENERAL INFORMATION FOR RESIDENT CLIENT

WHAT TO BRING

- Shampoo, soap, tooth brush, shaving kit, etc.
- Gym shoes (non-marking) and workout clothes
- Comfortable modest clothing is required
- Socks and underwear
- Swim suit (one-piece)
- Jacket / hoodies, etc. (weather / season appropriate)
- Small day pack
- Sufficient prescription medicine as prescribed and in the original containers or bubble wrapped for the duration of your treatment (see Medical portion of application)
- Over-the-counter medication and vitamins in the original packaging
- Debit and/or credit card
- Long distance calling card are a must for all calls
- Enough cigarettes for your entire stay (for smokers) or sufficient funds to purchase locally
- Personal health care number or Care Card (Canadian residents) and other valid identifications

PLEASE NOTE

- RLTC does not allow any forms of hair grooming on site, i.e. dyes, hair cuts.

WHAT NOT TO BRING

- T-shirts with offensive slogans or that promote alcohol or drugs
- Revealing clothing or inappropriate logo clothing
- Two-piece bathing suits
- Hair dyes
- Junk food
- Protein powders or workout supplements
- Sex toys
- Do NOT bring your own bedding, including blankets, pillows, cushions and stuffies.

INCIDENTAL MONEY

Resident Clients may need funds for medications they require during their stay in residence if not covered by medical; Phone cards are available for purchase at the administration building.