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

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 treatment?
- ☐ Completed and sent the Client Confidential Information Waiver?
- ☐ Completed and sent the Travel form?
- ☐ Given the Client the list of what to bring and what not to bring?
- ☐ Included the 3-page pre-admission medical report?
- ☐ Attached TB Results?

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

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

If your Client is receiving Income Assistance, have you?

- ☐ Forwarded the letter to the Employment and Income Assistance worker to sign?

If your 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.?

CLIENT CHECKLIST

- ☐ I have at least 14 days clean time from drugs and alcohol (more sobriety/clean time is better!).
- ☐ I have return travel arrangements and am prepared to absorb the costs if I choose to leave the treatment program early or am discharged.
- ☐ I have completed and submitted the form for Comfort Allowance if applicable.
- ☐ I have made a post-treatment counselling appointment with my referral worker or post-treatment alcohol and drug counsellor.
- ☐ I have read and understand the Round Lake Treatment Centre Program Guidelines.
- ☐ I have read and given copies of the Visitor Guidelines to all persons who may visit me or attend the Marble Ceremony.
- ☐ My medical coverage is currently active and includes prescription coverage.
- ☐ I have taken care of Doctor/Dentist/Eye appointments.
- ☐ I am free of outside interference which requires my attention during the six-week treatment program.
- ☐ 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, shaving supplies to last for six weeks.
- ☐ 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.

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NOTE: APPLICATION PACKAGE IS TO BE COMPLETED BY THE ALCOHOL & DRUG 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? ☐ FNIHB ☐ MEIA ☐ SELF		HOW IS TREATMENT PAID? (NON-STATUS / MÉTIS) ☐ FNIHB ☐ MEIA [1] ☐ SELF ☐ BAND	HOW WILL TRAVEL BE PAID **TO** & **FROM** RLTC? ☐ SELF ☐ BAND ☐ OTHER:_____
EMERGENCY CONTACT SURNAME [2]		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 THE SIX WEEK PROGRAM? ☐ YES ☐ NO

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

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 CLIENT HAS NO SOURCE OF INCOME OR SECURE HOUSING PRIOR TO TREATMENT, ARRANGEMENTS TO APPLY FOR INCOME ASSISTANCE SHOULD BE MADE PRIOR TO TREATMENT AS APPOINTMENTS ARE DIFFICULT TO SET UP WHILE CLIENT IS HERE.)

[1] Form to be completed, Page 23: Confirmation of Per Diem Funding and/or Comfort Allowance Paid through MEIA
[2] Client understands and accepts that Emergency Contact will be contacted in the event of an emergency

CLIENT NAME	DATE OF BIRTH

PART 2 – CLIENT INFORMATION (Continued) PLEASE PRINT CLEARLY

EDUCATION STATUS

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

☐ COLLEGE DIPLOMA ☐ UNIVERSITY DEGREE ☐ GRADUATE DEGREE

HAS THE CLIENT ATTENDED RESIDENTIAL SCHOOL? ☐ YES ☐ NO	IF YES, FOR HOW LONG? _____
HOW DOES THE CLIENT DESCRIBE THEIR RESIDENTIAL SCHOOL EXPERIENCE?	
DOES THE CLIENT HAVE DIFFICULTY WITH READING? ☐ YES ☐ NO	DOES THE CLIENT HAVE DIFFICULTY WITH WRITING? ☐ YES ☐ NO
DOES THE CLIENT HAVE ANY LEARNING PROBLEMS/DISABILITIES? ☐ YES ☐ NO	WILL THE CLIENT REQUIRE ASSISTANCE WITH READING/WRITING? [3] ☐ YES ☐ NO
DOES THE CLIENT AGREE TO COMPLETE AA STEPS 1 TO 3? ☐ YES ☐ NO	DOES THE CLIENT AGREE TO COMPLETE A GUIDED DAILY JOURNAL? ☐ YES ☐ NO

PART 3 – CLIENT LEGAL STATUS PLEASE PRINT CLEARLY

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

- We limit the number of Clients per intake who have current legal orders in place.
- The applicant must be released on the merit of completing their incarceration. Round Lake Treatment Centre does not participate in mandated treatment as a condition for eligibility of release from probation or parole. We are not under any obligation to accept a person who has been legally ordered to attend treatment.
- The Client must not have any upcoming legal issues/court dates. **ALL** court dates must be dealt with prior to admission. Court date interference with treatment may result in dismissal from the program until resolved.
- Applicants coming from an institution must reside in a halfway house, recovery house, John Howard House Society, or the community for a minimum of one month before entering the program.
- The Client is expected to cooperatively participate and follow our treatment and program guidelines with the understanding that we are under no obligation to keep a Client who does not participate or comply with treatment direction.
- We do not accept charged or convicted sex offenders.
- We do not accept 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 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	IS THE CLIENT RESTRICTED FROM GOING ON DAY OR WEEKEND PASSES? ☐ YES ☐ NO
NAME OF PROBATION OFFICER [4]	PROBATION OFFICER TELEPHONE
DOES THE CLIENT HAVE ANY PENDING CHARGES/COURT DATES? ☐ YES ☐ NO	DOES THE CLIENT HAVE ANY PREVIOUS CONVICTIONS/CHARGES? ☐ YES ☐ NO
IF YES, PLEASE LIST ALL PREVIOUS CONVICTIONS/CHARGES AND DATES	

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

[4] A copy of the Probation Order **MUST** be included with the application for treatment before the application can be assessed.

CLIENT NAME	DATE OF BIRTH

PART 4 – REFERRAL ASSESSMENT

PLEASE PRINT CLEARLY

HAS THE CLIENT ATTENDED RLTC BEFORE? ☐ YES ☐ NO	IF YES, DID THE CLIENT COMPLETE? ☐ YES – DATE _____ ☐ NO
IF NO, PLEASE EXPLAIN THE REASON FOR THE CLIENT'S NON-COMPLETION	
IS THE CLIENT APPLYING TO DO A REFRESHER? ☐ YES ☐ NO (IF YES, THE CLIENT MUST HAVE MAINTAINED COMPLETE ABSTINENCE SINCE HIS/HER ATTENDANCE AT TREATMENT)	
WHAT ARE THE CLIENT'S IMMEDIATE GOALS FOR A REFRESHER PROGRAM?	
THE CLIENT IS **COMMITTED** TO COMPLETE AN INTENSIVE, STRUCTURED TREATMENT PROCESS? ☐ YES ☐ NO	DOES THE CLIENT EXPRESS A DESIRE (WILLINGNESS) FOR HIM/HER SELF TO CHANGE? ☐ YES ☐ NO
IS THE CLIENT WILLING TO BE INVOLVED IN ALL TYPES OF INTENSIVE COUNSELLING ACTIVITIES? ☐ YES ☐ NO	DOES THE CLIENT EXPRESS A NEED TO CHANGE HIS/HER LIFE SITUATION? ☐ YES ☐ NO
DOES THE CLIENT BELIEVE ADDICTIONS ARE A PROBLEM TO HIS/HER WELL BEING? ☐ YES ☐ NO	DOES THE CLIENT BELIEVE SOBRIETY IS NEEDED IN ORDER TO CHANGE? ☐ YES ☐ NO
THE CLIENT UNDERSTANDS AND IS ABLE AND WILLING TO ADHERE TO RLTC PROGRAM GUIDELINES? (SEE PART 11, PAGE 20) ☐ YES ☐ NO	IF YES, HAS THE CLIENT READ AND UNDERSTOOD RLTC PROGRAM GUIDELINES? ☐ YES – DATE _____ ☐ NO

ARE THERE ANY MAJOR PROBLEMS IN THE CLIENT'S LIFE SITUATION RELATING TO ALCOHOL/DRUG ABUSE IN THE FOLLOWING AREAS?

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

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

IS THE CLIENT FREE OF **ALL FACTORS** THAT WOULD INTERFERE WITH THE RLTC PROGRAM? ☐ YES ☐ NO
(FAMILY, WORK, SCHOOL, MEDICAL, LEGAL, CHILDCARE, COURT APPEARANCE, ETC.)

DOES THE CLIENT HAVE DISCHARGE PLANS:

FOR BASIC NEEDS (HOUSING, FOOD, ETC.)	☐ YES	☐ NO
FOR CONTINUED AA OR NA OR OTHER SUPPORT GROUP ATTENDANCE	☐ YES	☐ NO
TO CONTINUE IN CULTURAL/SPIRITUAL ACTIVITIES AT LOCAL COMMUNITY	☐ YES	☐ NO
FOR OUTPATIENT/AFTERCARE COUNSELLING WITH YOU AS A/D COUNSELLOR	☐ YES	☐ NO

DOES THE CLIENT HAVE SPECIFIC NEEDS TO BE ADDRESSED IN TREATMENT? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN (SPIRITUAL, MENTAL, EMOTIONAL, PHYSICAL)

IS THE CLIENT WILLING TO PARTICIPATE IN FIRST NATIONS TREATMENT PROGRAM COMPONENTS SUCH AS SWEAT LODGE, DAILY SMUDGE, PIPE AND OTHER CULTURAL CEREMONIES? [5] ☐ YES ☐ NO

[5] Any cultural/spiritual items or ceremonial artefacts are recommended to be left at home. If items are brought into treatment, terms of access and usage will be assessed in consultation with the primary Counsellor.

CLIENT NAME	DATE OF BIRTH

PART 4 – REFERRAL ASSESSMENT (Continued) PLEASE PRINT CLEARLY

PRIOR TREATMENT 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), LEGAL

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

SPOUSAL SUPPORT PROGRAM (IF APPLICABLE)

WILL THE SPOUSE ATTEND ☐ 3 WEEK SPOUSAL SUPPORT PROGRAM[6] - IF YES, PROVIDE SPOUSE'S NAME: _____

☐ COMPLETE TREATMENT PROGRAM[7] ☐ N/A

DOES THE SPOUSE HAVE AN ALCOHOL/DRUG MISUSE PROBLEM?	☐ YES ☐ NO ☐ N/A	DOES THE SPOUSE RECEIVE OUTPATIENT A&D COUNSELLING?	☐ YES ☐ NO ☐ N/A
DOES THE SPOUSE ATTEND ANY SUPPORT GROUPS (AL ANON, ETC.)?	☐ YES ☐ NO ☐ N/A	ARE CHILDREN INVOLVED & CHILDCARE ISSUES ARE NOT A CONCERN?	☐ YES ☐ NO ☐ N/A

WHAT DOES THE SPOUSE IDENTIFY AS THE MAIN REASON FOR COMING IN FOR SPOUSAL SUPPORT?

HOW HAS THE SPOUSE BEEN PREPARING FOR COMING IN FOR TREATMENT?

☐ READ RLTC PROGRAM GUIDELINES ☐ ARRANGED FOR CHILDCARE ☐ SOUGHT COUNSELLING FOR SELF ☐ ATTENDED SUPPORT GROUP

WHAT ARE THE CLIENT'S IMMEDIATE GOALS FOR SPOUSAL SUPPORT PROGRAM?

SOCIAL SUPPORT SYSTEM

HAS THE 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
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)

DOES THE CLIENT HAVE A POST-TREATMENT APPOINTMENT SET? ☐ YES ☐ NO IF YES, DATE OF APPOINTMENT: _____

WHAT HAVE YOU DISCUSSED WITH YOUR CLIENT REGARDING AFTERCARE PLANS AND COMING BACK INTO THE COMMUNITY AND HOME?

[6] Must complete a full Application Package.

[7] If Spouse is attending the Complete Treatment Program, complete Part 6 – Couples Program on Page 9. **NOTE:** If the Spouse has less than six months' abstinence from A&Ds, they are recommended to attend a complete treatment program and must complete a separate application for treatment.

CLIENT NAME	DATE OF BIRTH

PART 4 – REFERRAL ASSESSMENT (Continued) PLEASE PRINT CLEARLY

CURRENT DIAGNOSTIC STATUS

HAS THE 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 [8] ☐ SUICIDE IDEATION ☐ SUICIDE ATTEMPTS [9]

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.

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

WHAT DOES THE CLIENT BELIEVE ARE HIS/HER:

STRENGTHS (ASSETS, RESOURCES): _____

NEEDS (LIABILITIES, WEAKNESSES): _____

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

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

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

REFERRAL WORKER / COUNSELLOR ASSESSMENT

IS THE CLIENT RECEIVING COUNSELLING FROM YOU? [10] ☐ YES ☐ NO

IF YES, HOW MANY PRE-TREATMENT COUNSELLING SESSIONS HAS THE CLIENT ATTENDED IN THE LAST THREE MONTHS? _____

HOW WAS THE CLIENT REFERRED TO YOU?	IS THE CLIENT RECEIVING OTHER COUNSELLING SERVICES? [11] ☐ YES ☐ NO IF YES, AGENCY NAME:

WHAT ISSUES HAS THE CLIENT WORKED ON IN HIS/HER SESSIONS? WHAT IS YOUR PERCEPTION OF THE CLIENT'S READINESS FOR TREATMENT?

WHAT DO YOU BELIEVE IS RLTC'S ROLE IN THE CLIENT'S OVERALL TREATMENT PLAN & THEIR MOTIVATION FOR COMING TO TREATMENT?

[8] If FAS/FAE please provide results along with the date of testing.
[9] Provide details such as date, whether Client was hospitalized and for how long, how attempt was made, is Client stable.
[10] Client must have a minimum of 6, 1 hour (or longer) pre-treatment counselling sessions with A&D Counsellor or Referral Worker.
[11] If YES, **ALL** Counsellors are required to complete and submit this portion of the application package.

CLIENT NAME	DATE OF BIRTH

PART 5 – CLIENT SCREENING

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:**	

CLIENT NAME	DATE OF BIRTH

PART 5 – CLIENT SCREENING (Continued) PLEASE PRINT CLEARLY

ALCOHOL / DRUG HISTORY

ALCOHOL AND/OR DRUG MISUSE IS CONSIDERED TO BE MISUSE IF YOU HAVE TRIED ANY OF THE FOLLOWING MORE THAN TWO TIMES IN ORDER FOR THE MOOD-ALTERING EFFECT. 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: CLIENT MUST HAVE 2 WEEKS (14 FULL DAYS) CLEAN FROM ALCOHOL AND DRUGS PRIOR TO ADMISSION TO TREATMENT. **NO EXCEPTIONS.** CLIENTS MAY BE DRUG TESTED UPON ADMISSION. IF TESTED POSITIVE HE/SHE WILL BE DECLINED ACCEPTANCE INTO THE PROGRAM.

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

CLIENT NAME	DATE OF BIRTH

PART 6 – COUPLES PROGRAM

PLEASE PRINT CLEARLY

NOTE: ONLY TO BE COMPLETED BY CLIENTS REQUESTING TO BE ADMITTED AS A COUPLE. **SPOUSE'S NAME:** _____

RLTC Couples Admission Criteria

To be accepted into the RLTC Couples Program, the following criteria must be met:

- Have a genuine desire to stop using alcohol or drugs, must possess a willingness to work with and explore relationship and family issues.
- Possess a willingness and commitment to complete the 34 or 41 day treatment program, *as a couple*. The Centre may request a written commitment prior to treatment.
- To have had a minimum of 2 sessions with a referral agent for assessment, screening and readiness to complete an intensive, highly structured Couples treatment program.
- To have had a minimum of 4 Couples sessions with a referral agent for Couple assessment and grounding of the Couple in preparation for Couples treatment.
- A full treatment application form must be submitted. All questions on the form must be answered fully by the Client and his/her referral agent.
- A completed medical report must be filled out and signed by a medical practitioner and submitted to RLTC Intake Coordinator. All medical, dental or other appointments must be taken care of prior to admission.
- Clients must be nineteen (19) years old or over and agree to complete the Alcohol and Drug program, in the event that one of the partners chooses to leave the Couples Program or is dismissed.
- The applying Couple must have been in a cohabited relationship for at least 6 months prior to submission of application.
- Both Clients must not have any upcoming legal issues/court cases. **ALL** court dates must be dealt with prior to admission to RLTC. Court date interference or any restrictions orders with treatment may result in dismissal from program until resolved. RLTC is not obligated to keep Clients who may be mandated to treatment by the courts or other agencies.
- Both Clients are expected to cooperatively participate and follow our treatment and program guidelines, with the understanding that RLTC is under no obligation to keep a Client(s) who does not participate or comply with treatment direction.
- Clients on probation or parole must inform the Intake Coordinator as part of the admission process, providing a copy of the probation/parole order and the name, contact information of the probation/parole officer and consent to confer with probation/parole officer.
- Both Clients must be free from alcohol and drugs for at least **three** weeks prior to his/her intake date. No exceptions. The purpose of the three week requirement of clean/sober time for the Couples Program is to provide a stronger foundation to focus on their relationship issues.

HAVE YOU SEEN THE COUPLE A MINIMUM OF FOUR SESSIONS?	☐ YES ☐ NO	IS THE COUPLE COMMITTED TO COMPLETE A FULL COUPLES PROGRAM?	☐ YES ☐ NO
HAS THE COUPLE ATTENDED ANY SUPPORT GROUPS (AL ANON, ETC.) TOGETHER?	☐ YES ☐ NO	ARE CHILDREN INVOLVED AND CHILDCARE ISSUES ARE NOT A CONCERN?	☐ YES ☐ NO

WAS THERE ANY SIGNIFICANT INCIDENTS OR EVENTS THAT LEAD TO THE DECISION TO APPLY FOR COUPLES TREATMENT?

WHAT DOES THE COUPLE IDENTIFY AS THE MAIN REASON FOR COMING IN FOR COUPLES TREATMENT?

HOW HAS THE COUPLE BEEN PREPARING FOR COMING IN FOR TREATMENT?

☐ READ RLTC PROGRAM GUIDELINES ☐ ARRANGED FOR CHILDCARE ☐ SOUGHT COUNSELLING ☐ ATTENDED SUPPORT GROUP

HOW LONG HAS THE COUPLE BEEN IN THE RELATIONSHIP? ☐ 6 MONTHS ☐ 1 TO 4 YEARS ☐ 5 TO 9 YEARS ☐ 10 TO 15 YEARS ☐ 20+ YEARS	IN THE EVENT THAT ONE OF THE PARTNERS LEAVES TREATMENT EITHER BY DISMISSAL OR OWN CHOICE, IS THE OTHER WILLING TO COMMIT TO FINISH HIS/HER TREATMENT? ☐ YES ☐ NO

DESCRIBE THE ROLE AND USE OF ADDICTIONS IN THE RELATIONSHIP

WHAT HAVE YOU DISCUSSED WITH THE COUPLE REGARDING AFTERCARE PLANS AND COMING BACK INTO THE COMMUNITY AND HOME?

DOES THE COUPLE HAVE A POST-TREATMENT APPOINTMENT SET? ☐ YES ☐ NO IF YES, DATE OF APPOINTMENT:_____

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, (CLIENT'S NAME) _____ HEREBY REQUEST AND GIVE PERMISSION TO DR/NP_____ TO RELEASE MY MEDICAL INFORMATION TO ROUND LAKE TREATMENT CENTRE AND MY ALCOHOL AND DRUG 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. I GIVE CONSENT TO HOGARTH'S PHARMACY TO ACCESS MY CLIENT MEDICATION PROFILE AND GIVE PERMISSION TO PREPARE AND DISPENSE ANY MEDICATION I NEED WHILE AT ROUND LAKE TREATMENT CENTRE.

_____ _____

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? [12]

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

[12] 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.

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) FOR A SIX WEEK PROGRAM. 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.

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 ALCOHOL AND DRUG TREATMENT, 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 TWO (2) WEEKS CLEAN FROM ALCOHOL, DRUGS AND PRESCRIPTION DRUGS FROM THE UNSAFE MEDICATIONS LIST PRIOR TO ADMISSION TO ROUND LAKE TREATMENT CENTRE**

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 Client not being accepted into Alcohol / Drug treatment.

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. Unsafe/mood-altering medications brought into treatment and taken in the two weeks prior to the Intake date will result in the Client's immediate discharge from the program.

CLIENT NAME	DATE OF BIRTH

PART 9 – METHADOSE 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.**

CLIENT NAME	DATE OF BIRTH

PART 9 – METHADOSE HARM REDUCTION TREATMENT (Continued) **PLEASE PRINT CLEARLY**

METHADOSE 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 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

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.**

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

CLIENT NAME	DATE OF BIRTH

PART 11 – FORMS

PLEASE PRINT CLEARLY

CONSENT TO ATTEND AND PARTICIPATE IN TREATMENT

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

1. _____ I understand that if I do not have two weeks (14 full days) free from alcohol and drugs, I will be immediately discharged from the program.
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 for treatment. 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 dealt with prior to admission to RLTC. I understand any court date interference may result in my being dismissed until resolved.
5. _____ I understand the Intake Coordinator will notify my referral worker by letter to confirm my acceptance to treatment.
6. _____ While in treatment, 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 treatment 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 treatment 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 Counsellor to confer with my probation officer, if applicable, regarding my progress and clarifying any details.
11. I, (Please Print 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-treatment conference call and progress during treatment, aftercare planning and Final Discharge Report.

REFERRAL WORKER'S NAME	
TITLE	NNADAP WORKER ☐ YES ☐ NO
ORGANIZATION / AGENCY NAME	
ADDRESS	

CITY	PROVINCE	POSTAL CODE
TELEPHONE	FAX	EMAIL
ALTERNATE CONTACT PERSON		

_____ _____

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 treatment. The 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 Client to inform their referral worker of the change. **This form is applicable for one year after the date signed unless revoked.**

CLIENT NAME	DATE OF BIRTH

PART 11 – FORMS (Continued) **PLEASE PRINT CLEARLY**

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (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 been in treatment and completion date for the purposes to arrange Travel/Comfort Allowance.
- ☐ Fax/Phone Probation Officer dates that I am in treatment and 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 Treatment Centre for the purpose of receiving a Comfort allowance or for making travel arrangements.

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

_____ _____

CLIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

NOTE: This form is applicable for one year after the date signed unless revoked.

CLIENT NAME	DATE OF BIRTH

PART 11 – FORMS (Continued) **PLEASE PRINT CLEARLY**

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (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

_____ _____

CLIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

NOTE: This form is applicable for one year after the date signed unless revoked.

CLIENT NAME	DATE OF BIRTH

PART 11 – FORMS (Continued) **PLEASE PRINT CLEARLY**

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

   _____ _____
   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 Client of the decision to have the Client 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 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 _____, 20_____

_____ _____
REFERRAL WORKER SIGNATURE CLIENT NAME

_____ _____
WORK TITLE AND AGENCY NAME CLIENT SIGNATURE

CLIENT NAME	DATE OF BIRTH

PART 11 – FORMS (Continued) **PLEASE PRINT CLEARLY**

RETURN ASSURANCE TRAVEL FORM

(NOTE: If the Client is discharged or voluntarily leaves treatment 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 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 _____ (Client's Name). I understand that if the Client is discharged or voluntarily leaves treatment before completion that Social Assistance and First Nations Inuit Health Branch will not cover return travel.

In the case that Round Lake Treatment Centre must pay for any of the 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 Client safely home.

Note: Any outstanding debts incurred by the above noted 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

PART 11 – FORMS (Continued) **PLEASE PRINT CLEARLY**

CONFIRMATION OF PER DIEM FUNDING AND/OR COMFORT ALLOWANCE PAID THROUGH THE MINISTRY OF EMPLOYMENT AND INCOME ASSISTANCE

Dear Employment and Income Assistance Worker:

We are requesting a confirmation of funding of treatment per diem and/or comfort allowance and/or travel for your Client who is scheduled to enter alcohol and drug treatment in the Round Lake Treatment Centre. This is to be done in order to ensure that the Client, whose treatment per diem is to be subsidized by the Ministry, does in fact have an active file in the system and has made proper arrangements.

TREATMENT PER DIEM: Will be taken care of by the Liaison Worker. The Client file is to remain with the District Office. Remember to include the intake and discharge date on the file.

COMFORT ALLOWANCE: Your office will retain the Client's file and will be responsible for a comfort allowance which 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 for the Client's file and give a copy to the Client as he/she is required to return this to the referral worker to fax to us at 250-546-3227.

I also 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 _____, 20_____

CLIENT SIGNATURE	CLIENT SOCIAL INSURANCE NUMBER
PRINT 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 PROGRAM 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. Full Program Guidelines and more information on what to expect can be found on the website – **Please read these guidelines carefully and be prepared to follow them for the safety of all people.**

Alcohol and Drugs
The possession or use of alcohol or non-prescribed drugs by Clients while in treatment is not acceptable and will result in immediate dismissal from treatment. A personal baggage check is conducted upon entry and return from weekend and/or day passes.

Phone Calls
You can make one phone call to confirm your safe arrival by collect call or by calling card. During the first week you may only make emergency phone calls. You will then require a phone slip signed by your primary counsellor to make calls. Calls are limited to five minutes. You can check for mail at the administration building after 4:00 p.m. Monday to Friday or the CSW's office after hours.

Weekend Pass or Weekend Day Pass
Passes are a privilege, not a right – they must be earned. You can apply for a pass which will be reviewed, then approved or denied by the Counsellor which is based on your progress. If approved, arrangements are to be made for your chores and your own transportation (destination must not exceed 100 miles or 160 kms from the Centre). Inform staff when you are leaving, when you arrive back or if you have cancelled your outing or day/weekend pass.

Visitors
Refer to Visitor Guidelines at www.roundlaketreatmentcentre.ca.

Health and Safety
Smoking is only allowed in the designated smoking areas. The doors to all occupied rooms will remain unlocked in case of fire. All medication will be given to the CSW at intake. A high standard of personal hygiene is required, including daily baths/showers. Use only the bed you are assigned to and daily upkeep of your assigned room is a personal responsibility. Sleeping areas are private quarters. No visiting in another Client's room or inviting other Clients into your room. Inform staff if you wish to smudge your sleeping area. Refrain from horseplay, running in the hallways and refrain from profanity. Withdrawal/dismissal from the program requires prompt exit from the premises.

Other
All money and valuables may be turned in at the CSW's office. Round Lake is not responsible for lost or stolen items. Personal items may be accessed on weekends in consultation with the CSW. Appropriate dress code required. Sleepwear is to be worn within your bedroom only. No hats or sunglasses in circle area or dining area. Carefully read and understand the Client Manual. No unsupervised group/circle work at any time. No "counselling" of other Clients. No junk food allowed in vehicles or at the Centre. Refrain from lending money, cigarettes or clothing, etc. If you have your own vehicle, keys must be turned into the CSW staff. Ensure that you make your own marble as it is a meaningful part and symbol of your recovery. Clients are not to sell items to each other or to staff.

Client Discharge
Client discharge will occur when a Client has either caused injury to another person or the treatment centre or property, used alcohol and/or drugs while in treatment, or has become involved in an intimate relationship with another Client and is unwilling to stop the relationship. RLTC has a zero tolerance for violence of any nature.

Discharge from the Program
Clients who have completed treatment or voluntarily leave or are discharged from the program are to have no further contact with Clients still in treatment. We will intercept any incoming mail, email or calls from past Clients or any person attempting to interfere with your treatment. All communications received, if any, will be provided to you upon completion of treatment once you leave.

CLIENT NAME	DATE OF BIRTH

PART 13 – GENERAL INFORMATION FOR 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 that are sealed and unopened
- 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 slogan or images that promote drugs, alcohol, gang affiliation and/or have sexual or violent images
- Revealing clothing
- Two-piece bathing suits
- Mouthwash or other items containing alcohol (i.e. perfume, hand sanitizer, hair dye, nail polish)
- Laptop computers, TVs
- Portable music players (iPods, etc.), personal entertainment items
- Junk food
- Cameras
- Protein powders or workout supplements
- Sex toys
- Work or education course material
- Weapons, knives, scissors
- Do NOT bring your own bedding, including blankets, pillows, cushions and stuffies
- Previously opened over-the-counter medication, vitamins, herbals and/or supplements

INCIDENTAL MONEY

Clients will need funds for medications they require during treatment if not covered by medical; may want to have some spending money when on outings, or on weekend/day passes, etc. Phone cards can be purchased.

READING MATERIAL

Only recovery-related reading material is allowed at RLTC and will be assessed by primary counsellor for appropriateness. Your own personal books can be signed out or assigned while in treatment.

LAUNDRY

Laundry facilities and products are available for Clients to wash and dry their personal items.

CLIENT NAME	DATE OF BIRTH

ROUND LAKE TREATMENT CENTRE

PRE-ADMISSION CHECKLIST

TO BE COMPLETED BETWEEN REFERRAL WORKER AND CLIENT.

FOR THE SUCCESS OF YOUR CLIENT, PLEASE GO OVER THIS CHECKLIST TO PREVENT THE CLIENT FROM HAVING TO MISS VALUABLE TIME AWAY FROM THE TREATMENT PROGRAM.

INTAKE DATE: _____ ***REVIEW AND FAX ONCE COMPLETED 250-546-3227***

☐ Client informed of intake date and clean time requirement, **Pre- clean time essential**, 14 days clean and sober from alcohol, drugs and unsafe prescription medications. Please ensure supports are in place for client to meet this requirement.

☐ All documentation sent to Round Lake (If applicable Probation order, Consent to Release signed).

☐ **All Medical Prescription(s) filled** by Hogarth's Pharmacy. Fill all prescribed medications through Hogarth's pharmacy by having your doctor fax the prescription to be blister packaged for the length of your stay at RLTC. **NO EXCEPTIONS**. Hogarth's Pharmacy **Fax #250-545-4392**

☐ Review Pre-Admission Medical; ensure there are **no acute or immediate healthcare concerns unresolved**. If medical needs become a deterrent from the program, client will be given a medical leave and asked to return at a later intake date.

☐ Reminder, the water is very hard at RLTC, and dries the skin, bring lotion if sensitive skin.

☐ Acceptable natural sleep aides: ***Epsom salt, Melatonin, Calcium Magnesium with Vit D3 supplement, Lavender Oil*** are encouraged as our clients often have troubles sleeping during the first two weeks of treatment; Clients to supply own above noted sleep aides.

☐ Client has secured travel arrangements **i.e.:** Taxi fare **to and from** Bus Depot/Airport to Round Lake.

☐ Do not bring any aerosol products or strong perfumes and/or body lotions due to allergies.

☐ **All** Dental Aliments have been taken care of **PRIOR** to treatment.

☐ Provide client with Round Lakes after hours contact in case of late arrivals or emergency.

24 hour CSW telephone # 250-546-3077 ext. 226

_____ _____

Referral Worker (Signature) **(Date)**

_____ _____

Client (Signature) **(Date)**

CLIENT NAME	DATE OF BIRTH

ROUND LAKE TREATMENT CENTRE

STAND-BY PRE-ADMISSION CHECKLIST

TO BE COMPLETED BETWEEN REFERRAL WORKER AND CLIENT.

FOR THE SUCCESS OF YOUR CLIENT, PLEASE GO OVER THIS CHECKLIST TO PREVENT THE CLIENT FROM HAVING TO MISS VALUABLE TIME AWAY FROM THE TREATMENT PROGRAM.

STAND-BY INTAKE DATE: _____ ***REVIEW AND FAX ONCE COMPLETED 250-546-3227***

☐ Client informed of intake date and clean time requirement, **Pre- clean time essential**, 14 days clean and sober from alcohol, drugs and unsafe prescription medications. Please ensure supports are in place for client to meet this requirement.

☐ All documentation sent to Round Lake (If applicable Probation order, Consent to Release signed).

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