Round Lake Treatment Centre (RLTC) Application Package

200 Emery Louis Road, Armstrong, BC V0E 1B5
Phone: 250-546-8848 / Fax: 250-546-3227
www.roundlaketreatmentcentre.ca
Email: Intake@roundlake.bc.ca

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

PART 1 – APPLICANT IDENTIFICATION

PLEASE PRINT CLEARLY

SURNAME (LEGAL)	FIRST NAME MIDDLE NAME	PREFERRED NAME if applicable
ADDRESS	CITY, PROVINCE POSTAL CODE	BIRTH DATE (DD / MM / YYYY)
TELEPHONE	EMAIL	SELF IDENTIFIED GENDER ☐ MALE ☐ FEMALE ☐ OTHER
MARITAL STATUS ☐ SINGLE ☐ COMMON-LAW ☐ DIVORCED ☐ MARRIED ☐ SEPARATED ☐ WIDOWED		
BAND OR TREATY MEMBER ☐ YES ☐ NO	ABORIGINAL ANCESTRY ☐ INUIT ☐ MÉTIS ☐ NON-STATUS ☐ N/A BAND OR TREATY NAME:	ON RESERVE ☐ YES ☐ NO
STATUS NUMBER □ N/A	SOCIAL INSURANCE NUMBER	CARE CARD NUMBER
HOW IS TREATMENT PAID? Funding resources must be in place for confirmation to attend is sent. ☐ FNIHB ☐ MEIA ☐ SELF ☐ BAND		CLIENT TRAVEL WILL BE PAID **TO** & **FROM** RLTC? ☐ SELF ☐ BAND ☐ OTHER:_____
EMERGENCY CONTACT [1]	EMERGENCY CONTACT TELEPHONE	EMERGENCY CONTACT EMAIL
EMERGENCY CONTACT RELATIONSHIP TO CLIENT	SECONDARY EMERGENCY CONTACT TELEPHONE	

PART 2 – REFERRAL INFORMATION

REFERRAL WORKER NAME	TITLE / POSITION	EMAIL
ORGANIZATIONAL NAME	TELEPHONE	FAX
ORGANIZATIONAL ADDRESS (INCLUDE POSTAL CODE)		IS THE APPLICANT RECEIVING COUNSELING FROM YOU? ☐ YES ☐ NO
WHAT KIND OF HEALING SUPPORTS HAS THE APPLICANT HAD IN LAST 3 MONTHS?		

SOCIAL SUPPORT SYSTEM HAS THE CLIENT EVER ATTENDED:

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

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

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

APPLICANT NAME	DATE OF BIRTH

WHAT HAVE YOU DISCUSSED WITH YOUR CLIENT REGARDING AFTERCARE PLANS AND COMING BACK INTO THE COMMUNITY AND HOME?
WHAT ISSUES HAS THE CLIENT WORKED ON IN HIS/HER SESSIONS?
WHAT IS YOUR PERCEPTION OF THE APPLICANT'S READINESS FOR TREATMENT?

PART 3 – INCOME AND EDUCATION

SOURCE OF INCOME/ 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 APPLICANT 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 APPLICANT IS HERE.)

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 APPLICANT HAVE DIFFICULTY WITH READING? ☐YES ☐ NO	DOES THE APPLICANT HAVE DIFFICULTY WITH WRITING? ☐ YES ☐ NO
WILL THE CLIENT REQUIRE ASSISTANCE WITH READING/WRITING? [1] ☐ YES ☐ NO	THE APPLICANT AGREES TO COMPLETE AA STEPS 1 TO 3? ☐ YES ☐ NO

PART 4 – APPLICANT LEGAL STATUS

CURRENT LEGAL STATUS IS NOT APPLICABLE ☐	IS THE APPLICANT MANDATED TO ATTEND TREATMENT? AND / OR HAVE LEGAL ORDERS OR BAIL ORDERS IN PLACE? ☐ YES ☐ NO
IF YES, PLEASE SPECIFY THE TYPE OF LEGAL ORDER IN PLACE:	
NAME OF BAIL OR PROBATION OFFICER [2]	BAIL OR PROBATION OFFICER TELEPHONE
BAIL OR PROBATION OFFICER EMAIL:	BAIL OR PROBATION OFFICER ADDRESS:
IS THE APPLICANT RESTRICTED FROM GOING ON DAY OR WEEKEND PASSES? ☐ YES ☐ NO	THE APPLICANT UNDERSTANDS AND GIVES CONSENTS THAT THEIR PROBATION OFFICER WILL BE CONTACTED? **APPLICANT INTIALS** _____ ☐ YES
WERE THE CHARGES ALCOHOL/DRUG RELATED? ☐ YES ☐ NO	DOES THE APPLICANT HAVE ANY PREVIOUS LEGAL CHARGES? ☐ YES ☐ NO
IF YES, TO PREVIOUS CHARGES PLEASE SPECIFY THE TYPE OF CHARGES:	

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

- RLTC is not under any obligation to accept an applicant who has been legally ordered or mandated to attend treatment and we reserve the right to limit the number of clients per intake who have current legal orders in place.
- All applicants must NOT have any upcoming legal issues/court dates. **ALL** court dates must be dealt with prior to admission.
- We do not accept charged or convicted sex offenders nor do we accept clients with the following legal conditions:
  - Electronic Monitoring or Temporary Absence

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

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

APPLICANT NAME	DATE OF BIRTH

- 24 Hour Supervision or Day Parole
- All other legal conditions will be reviewed on a case by case basis

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, (Please Print Applicant's Name) _____ hereby give permission for RLTC staff to contact my referral worker(s) listed and my bail / probation officer for the release of information in a pre-treatment conference call and if accepted into treatment the disclosure of my progress during treatment, aftercare planning and Final Discharge Report.

PART 5 – FAMILY AND LIVING ARRANGEMENTS

FAMILY STATUS APPLICANT CURRENTY IS:

☐ SINGLE PARENT ☐ LIVING WITH SPOUSE & CHILDREN ☐ LIVING ALONE ☐ LIVING WITH FRIENDS ☐ LIVING WITH IMMEDIATE FAMILY ☐ EXTENDED FAMILY

DOES THE CLIENT HAVE SECURE CHILD CARE FOR THE SIX WEEK PROGRAM? ☐ YES ☐ NO

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

HAS THE CLIENT BEEN MANDATED TO TREATMENT BY MCFD?	☐ YES ☐ NO	IS A SOCIAL WORKER CURRENTLY INVOLVED WITH THE FAMILY?	☐ YES ☐ NO
IS THERE ANY SUPERVISION ORDER IN PLACE BY MCFD?	☐ YES ☐ NO	DOES THE APPLICANT HAVE ANY NO-CONTACT ORDERS WITH HIS/HER SPOUSE?	☐ YES ☐ NO

IF YES, THE APPLICANT UNDERSTANDS RLTC IS NOT OBLIGATED TO KEEP THEM IF THEY ARE NOT WILLING TO ADHERE TO RLTC SAFETY GUIDELINES OF THE PROGRAM AND UNDERSTAND THAT THEY MUST PARTAKE FULLY IN ALL PROGRAM ACTIVITIES? INITIALS _____

PART 6 – FOUR LIFE AREAS ~ WELLNESS

MENTAL

CHECK ALL APPLICABLE BOXES

☐ DEPRESSION ☐ ANXIETY/PANIC DISORDER ☐ ANY TYPE OF MENTAL DISORDER ☐ BRAIN / HEAD INJURY ☐ ADD / ADHD

☐ FAS / FAE [3] ☐ SUICIDE IDEATION ☐ SUICIDE ATTEMPTS [4] ☐ SELF HARM TENDENCY

IF THE APPLICANT HAS A HISTORY OF SUICIDE? IF YES- DATE OF LAST ATTEMPT_____ ASSESSED LEVEL OF RISK_____	IF THE APPLICANT HAS A HISTORY OF SELF HARM? ☐ YES ☐ NO IF YES –TYPE OF HARM: _____

HAS THE CLIENT EVER BEEN PROFESSIONALLY ASSESSED BY A PSYCHOLOGIST OR PSYCHIATRIST? IF YES- SPECIFIY[5] ☐ YES ☐ NO

WHAT DO YOU BELIEVE IS RLTC'S ROLE IN THE APPLICANT'S OVERALL TREATMENT PLAN?

EMOTIONAL

CHECK ALL APPLICABLE BOXES

☐ TRAUMA (PTSD) ☐ ANXIETY/PANIC DISORDER ☐ ANGER / ACTING OUT ☐ GRIEF AND/OR LOSS ☐ SEXUAL HARM / ABUSE ☐ FOSTER HOME CARE

☐ FAMILY TRAUMA (CHILD APPREHENSION, CUSTODY PROBLEMS, LATERAL VIOLENCE, MARRIAGE PROBLEMS/BREAKDOWN, ETC.) ☐ INDIAN RESIDENTAL SCHOOL

☐ FAMILY VIOLENCE (ASSAULTS, BATTERY TRAUMA ~)

PLEASE CLARIFY IN DETAIL ANY OF THE ABOVE:

DOES THE CLIENT BELIEVE SOBRIETY IS NEEDED IN ORDER FOR LIFE TO CHANGE? ☐ YES ☐ NO	DOES THE APPLICANT HAVE ANY SPECIAL NEEDS WE NEED TO BE AWARE OF? IF YES- PLEASE SPECIFY. ☐ YES ☐ NO

[3] If FAS/FAE please provide results along with the date of testing.

4 Provide details such as date, whether Applicant was hospitalized, for how long, and how attempt was made.

[5] Provide dates and details and attach copy of **ALL** Psychological Assessments

APPLICANT NAME	DATE OF BIRTH

PHYSICAL

DOES THE APPLICANT HAVE CHRONIC OR ACUTE PHYSICAL OR MEDICAL LIMITATIONS THAT WOULD PREVENT THEM FROM FULL PARTICIPATION IN THE PROGRAM?	☐ YES ☐ NO	IF YES – PLEASE PROVIDE DETAIL OF MEDICAL ISSUE:	
DOES THE APPLICANT REQUIRE A WHEEL CHAIR ACCESSIBLE BEDROOM AND/OR BATHROOM?	☐ YES ☐ NO	DOES THE APPLICANT HAVE ANY SPECIAL NEEDS? IE) HEARING AIDS	☐ YES ☐ NO
THE APPLICANT IS ABLE TO PARTICIPATE IN DOING DAILY LIVING CHORES, GROUP SESSIONS, RECREATIONAL OR CULTURAL ACTIVITIES?	☐ YES ☐ NO	DOES THE APPLICANT BELIEVE ADDICTIONS ARE A PROBLEM TO HIS/HER WELL BEING?	☐ YES ☐ NO

SPIRITUAL

IS THE CLIENT WILLING TO PARTICIPATE IN FIRST NATIONS TREATMENT PROGRAM COMPONENTS SUCH AS SWEAT LODGE, DAILY SMUDGE, PIPE AND OTHER CULTURAL CEREMONIES? [6] ☐ YES ☐ NO

PLEASE SHARE ANY SPIRITUAL OR CULTURAL INVOLVEMENT THE APPLICANT FEELS IS NECESSARY FOR THEIR HEALING:

WHAT DOES THE APPLICANT BELIEVE ARE HIS/HER:

STRENGTHS (ASSETS, RESOURCES): _____

NEEDS (LIABILITIES, WEAKNESSES): _____

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

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

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

[6] 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.

APPLICANT NAME	DATE OF BIRTH

PART 7 – APPLICANT SUBSTANCE USE HISTORY

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 / RARELY)	**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: APPLICANTS MUST HAVE 2 WEEKS (14 FULL DAYS) CLEAN FROM ALCOHOL AND DRUGS PRIOR TO ADMISSION. **NO EXCEPTIONS.** APPLICANTS 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. **PLEASE REFER TO AND COMPLETE APPENDIX B ~MAST/DAST ASSESMENT**

APPLICANT NAME	DATE OF BIRTH

PART 8 – TREATMENT HISTORY

HAS THE APPLICANT ATTENDED RLTC BEFORE? ☐ YES ☐ NO	IF YES, DID THEYCOMPLETE? ☐ YES – DATE _____ ☐ NO
IF NO, PLEASE CLARIFY REASON FOR THE APPLICANT'S NON-COMPLETION:	

PLEASE 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 / YEAR	ISSUES WORKED ON	COMPLETED
1.				☐ YES ☐ NO
2.				☐ YES ☐ NO
3.				☐ YES ☐ NO
4.				☐ YES ☐ NO

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?

PART 9 - OPIOID AGONIST TREATMENT ~ OAT

COMPLETE ONLY FOR APPLICANTS CURRENTLY ON OAT THERAPY

PRESCRIBING PHYSICIAN / NURSE PRACTITIONER:	TELEPHONE:	FAX:
ADDRESS:		

LENGTH OF OPIOID AGONIST TREATMENT	☐ METHADONE DOSE_____ (mg)	☐ SUBOXONE DOSE_____ (mg)

NOTE: PLEASE REFER TO AND COMPLETE APPENDIX C ~ METHADONE & SUBOXONE PROGRAM CONTRACT

PART 10 – PHYSICIAN or NURSE PRACTITIONER'S REPORT

(MUST BE COMPLETED BY APPLICANT'S PHYSICIAN OR NURSE PRACTITIONER)

SURNAME (LEGAL)	FIRST NAME	MIDDLE NAME
CARE CARD NUMBER	STATUS NUMBER	

IS THIS PATIENT ON ANY MEDICATIONS?[7] ☐ YES ☐ NO **(PLEASE GIVE AN ACCURATE PRE-ADMISSION MEDICATION LIST FOR ASSESSMENT)**

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

[7] ALL APPLICANT CLIENT'S MEDICATIONS ARE REQUIRED TO BE BLISTER PACKED ON A WEEKLY BASIS. **NOTE:** ONCE IN RECEIPT OF **CONFIRMATION OF THE APPLICANT 'S ACCEPTANCE TO RLTC, THE APPLICANT'S PHYSICIAN or NURSE PRACTITIONER MUST MAIL THE ORIGINAL PRESCRIPTION(S) TO HOGARTH'S PHARMACY 102-3310 32ND AVE VERNON, BC V1T 2M6** FOR A SIX WEEK PROGRAM.

APPLICANT NAME	DATE OF BIRTH

INFORMED CONSENT MUST BE COMPLETED WITH PATIENT

I, (APPLICANT'S NAME) _____ HEREBY REQUEST AND GIVE PERMISSION TO _____ _____ (TREATING PHYSICIAN / NURSE PRACTITIONER) TO RELEASE MY MEDICAL INFORMATION TO ROUND LAKE TREATMENT CENTRE (RLTC) AND MY ALCOHOL AND DRUG REFERRAL WORKER ACTING ON MY BEHALF FOR ADDMISSION INTO TREATMENT. I ALSO PROVIDE CONSENT TO HAVE THE RLTC NURSE, COUNSELLOR OR TREATMENT STAFF TO CONSULT OR INQUIRE WITH MY ABOVE NAMED HEALTH CARE PROVIDER ON ANY OF MY MEDICAL NEEDS WHILE IN TREATMENT.

_____ _____

APPLICANT CLIENT SIGNATURE DATE

NOTE: The Patient 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 Patient client to inform of the change otherwise this consent is applicable for one year after the date signed unless revoked.

FUNCTIONAL INQUIRY AND PHYSICAL EXAM

ALLERGIES ☐ YES ☐ NO IF YES, PLEASE SPECIFY _____ SPECIFY DIETARY ALLERGIES _____

NOTE: PATIENT MUST HAVE EPI-PEN OR ANA-KIT IF ALLERGIC TO BEES OR NUTS.

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:	
PREGNANT? ☐ YES ☐ NO IF YES, WHAT TRIMESTER? _____	ANY PRIOR PROBLEMATIC PREGNANCIES? [8]			
MENSTRUAL LMP:				
SKIN	INFESTATIONS:	INFECTIONS:		
STDs ☐ YES ☐ NO	NEG	POS	TYPE:	
HEP C ☐ YES ☐ NO	NEG	POS	HIV / AIDS TEST? ☐ YES ☐ NO	NEG POS

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

[8] For Pregnant patient client: Will be asked to sign a waiver form and due to rural location of the Centre, RLTC is not able to accept pregnant applicant clients that have had prior problematic or difficult pregnancy history.

APPLICANT NAME	DATE OF BIRTH

PART 10 – 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 UP TO EIGHT HOURS A DAY?
- NAME OF DOCTOR WHO PROVIDED THE DIAGNOSIS :_____
- 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 THE MANTOUC TEST IS POSITIVE, A CHEST XRAY MUST BE ARRANGED AND RESULTS OF THE XRAY MAY TAKE UP TO 6 WEEKS.

- **HAVE TWO (2) WEEKS CLEAN FROM ALCOHOL, DRUGS AND PRESCRIPTION DRUGS FROM THE UNSAFE MEDICATIONS LIST PRIOR TO ADMISSION TO ROUND LAKE TREATMENT CENTRE. CRYSTAL METH USE CLEAN TIME IS FIVE (5) MONTHS ABSTINENCE. NO EXCEPTIONS**

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 **APPENDIX A – SAFE/UNSAFE MEDICATION LIST**–as non-compliance with said list will result in the Applicant not being accepted into Alcohol / Drug treatment.

APPLICANT NAME	DATE OF BIRTH

PART 11 – FORMS

PLEASE PRINT CLEARLY

CONSENT TO ATTEND AND FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, (Please Print Applicant's Name) _____ consent to attend and participate at RLTC and hereby give permission for the Treatment Centre staff to contact the identified persons listed below for release of information in regard to pre-treatment information, contact and attendance verification.

If accepted, I consent for the Treatment Counsellor to confer with those listed below, if applicable, regarding my progress and clarifying any detail in regard to my progress during treatment, aftercare planning and Final Discharge Report.

REFERRAL WORKER	ORGANIZATION / AGENCY NAME	EMAIL PHONE FAX
BAIL and or PROBATION OFFICER	ORGANIZATION / AGENCY NAME	EMAIL PHONE FAX
MEDICAL PRACTITIONER(S)	ORGANIZATION / AGENCY NAME	EMAIL PHONE FAX
EMPLOYMENT AND INCOME ASSISTANCE WORKER	ORGANIZATION / AGENCY NAME	EMAIL PHONE FAX
ALTERNATE REFERRAL CONTACT PERSON	ORGANIZATION / AGENCY NAME	EMAIL PHONE FAX
EMERGENCY CONTACT PERSON	RELATIONSHIP TO APPLICANT	PHONE

NOTE: The alternate referral contact person is for confirmation or admission processing only – the Alternate referral contact or the Emergency contact will not be included in the release of confidential information prior to, during or after treatment. The Applicant Client may change or revoke this release at any time by providing written notice to Round Lake Treatment Centre. It is up to the Applicant Client to inform their referral worker of the change. **This form is applicable for one year after the date signed unless revoked.**

_____ _____

APPLICANT SIGNATURE DATE

_____ _____

REFERRAL WORKER SIGNATURE DATE

APPLICATION CHECKLIST FOR REFERRAL WORKER

All applications must review Appendix A, Appendix F, submit Appendix B, and Appendix D. If the Applicant client is on OAT therapy **Appendix C** must be submitted as part of the application.

Have You?

- ☐ Ensured you have reviewed **APPENDIX A** ~ SAFE AND UNSAFE MEDICATIONS? To ensure that your Applicant is not taking unsafe medications?
- ☐ Completed and sent the **APPENDIX B** ~ MAST / DAST ASSESSMENT for treatment?
- ☐ Completed and sent the **APPENDIX D** ~ TRAVEL FORM?
- ☐ Provided the Applicant the list of what to bring and what not to bring?
- ☐ Ensured that ALL necessary, supporting and requested documents are included in the application?

If the Applicant is on OAT Therapy APPENDIX C MUST BE COMPLETED. Check appropriate box to submit.

- ☐ Completed and sent a signed copy of the Applicant's Methadone Verification Form?
- ☐ Completed and sent a signed copy of the Applicant's Suboxone Verification Form?

If the Applicant is receiving Income Assistance, have you competed APPENDIX E ~ LETTER TO MINISTRY WORKER**?**

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

If the Applicant is on probation, bail order or parole, have you?

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

CLIENT CHECKLIST

- ☐ I have at least 14 days clean time from drugs and alcohol. CRYSTAL METH USE CLEAN TIME IS FIVE (5) MONTHS ABSTINENCE. NO EXCEPTIONS (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 read and understand the Round Lake Treatment Centre Program Guidelines.
- ☐ 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 a bank card, and identification (for cashing cheques).

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
- 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
- Two-piece bathing suits
- Hair dyes
- Laptop computers, TVs
- Portable music players (iPods, etc.)
- Junk food
- Cameras
- Protein powders or workout supplements
- Sex toys
- Work or education course material
- Do NOT bring your own bedding, including blankets, pillows, cushions and stuffies.

INCIDENTAL MONEY

Applicant 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. There is a small library of such books or 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.