Round Lake Treatment Centre (RLTC)
200 Emery Louis Road, Armstrong, BC V4Y 0X3
www.roundlaketreatmentcentre.ca

Painted Turtle Lodge Application Package

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

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

* THIS APPLICATION IS ONLY APPLICABLE IF ATTENDING ANOTHER ALCOHOL & DRUG PROGRAM OTHER THAN RLTC

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		APPLICANTS 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?		

PART 3 – REFERRAL ASSESSMENT

HAS THE APPLICANT ATTENDED RLTC BEFORE? ☐ YES ☐ NO	IF YES, DID THEY COMPLETE? ☐ YES – DATE _____ ☐ NO
COMPLETING A RESIDENTIAL TREATMENT PROGRAM OR IN PATIENT DAY PROGRAM AND MAINTAINING SOBRIETY IS A REQUIRMENT TO ATTEND THE PAINTED TURTLE LODGE RECOVERY HOME; WHICH PROGRAM HAS THE APPLICANT CURRENTLY COMPLETED?	
IS THE APPLICANT COMMITTED TO COMPLETE A STRUCTURED, THERAPEUTIC POST RECOVERY PROGRAM? ☐ YES ☐ NO	DOES THE APPLICANT EXPRESS A DESIRE FOR HIM/HERSELF TO CHANGE? ☐ YES ☐ NO

APPLICANT NAME	DATE OF BIRTH

DOES THE APPLICANT EXPRESS THE NEED FOR A LONGER PERIOD OF LIVING IN SOBER HOUSING? ☐ YES ☐ NO	DOES THE APPLICANT ACCEPT AND UNDERSTAND THEY WILL BE IN A COMMUNAL LIVING ENVIRONMENT? ☐ YES ☐ NO

WHAT AREAS HAS THE APPLICANT IDENTIFIED THAT REQUIRE 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

LIFE SKILL DEVELOPMENT (MANAGING HOUSING, FOOD, AND MONEY, ETC.)	☐ YES	☐ NO
CONTINUED AA OR NA OR SEEKING SPONSORSHIP	☐ YES	☐ NO
TO START OR CONTINUE IN CULTURAL/SPIRITUAL ACTIVITIES	☐ YES	☐ NO
EMPLOYMENT OR VOLUNTEER ACTIVITIES	☐ YES	☐ NO
RELAPSE PREVENTION TOOLS	☐ YES	☐ NO

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

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

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/SPIRITUAL SUPPORT SYSTEM

HAS THE APPLICANT EVER ATTENDED:

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

APPLICANT NAME	DATE OF BIRTH

PART 4 – 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 ATTENDING THE RECOVERY HOME)

EDUCATION STATUS

HIGHEST LEVEL COMPLETED: ☐ GRADE COMPLETED _____ ☐ HIGH SCHOOL DIPLOMA ☐ TRADE SCHOOL ☐ COLLEGE DIPLOMA ☐ UNIVERSITY DEGREE ☐ GRADUATE DEGREE

HAS THE APPLICANT ATTENDED RESIDENTIAL SCHOOL? ☐ YES ☐ NO	IF YES, FOR HOW LONG? _____
HOW DOES THE APPLICANT DESCRIBE THEIR RESIDENTIAL SCHOOL EXPERIENCE?	
DOES THE APPLICANT HAVE DIFFICULTY WITH READING? ☐YES ☐ NO	DOES THE APPLICANT HAVE DIFFICULTY WITH WRITING? ☐ YES ☐ NO

PART 5 – 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 [1]	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
  - 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.

[1] 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

PART 6 – 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 7 – 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 [2] ☐ SUICIDE IDEATION ☐ SUICIDE ATTEMPTS [3] ☐ 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 APPLICANT EVER BEEN PROFESSIONALLY ASSESSED BY A PSYCHOLOGIST OR PSYCHIATRIST? IF YES- SPECIFIY[4] ☐ YES ☐ NO

WHAT IS THE APPLICANT CURRENTLY USING AS COPING SKILLS AS PART OF THEIR OVERALL RECOVERY PLAN? DO THEY EXPRESS A DESIRE TO LEARN OTHER COPING SKILLS, PLEASE LIST.

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 APPLICANT 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

WHAT DO YOU BELIEVE IS THE APPLICANT'S MOTIVATION FOR RECOVERY?

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

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

[4] 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? [5] ☐ 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 APPLICANTS OWN WORDS, WHAT ARE THEIR PRESENTING PROBLEMS AND CHALLENGES? _____

[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.

APPLICANT NAME	DATE OF BIRTH

PART 8 – 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

APPLICANT NAME	DATE OF BIRTH

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 ~ OAT MAINTENANCE PROGRAM		

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?[6] ☐ 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.			

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.

[6] 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 FAX THE ORIGINAL PRESCRIPTION(S) TO JAMIE'S PHARMACY** (FAX: 250-541-8907) FOR A SIX WEEK PROGRAM.

APPLICANT NAME	DATE OF BIRTH

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? [7]

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.

PART 11 – 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?

[7] 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

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 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 Medications 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 12 – FORMS

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

200 Emery Louis Road, Armstrong, BC V4Y 0X3 Phone: 250-546-8848 / Fax: 250-546-3227
www.roundlaketreatmentcentre.ca Email: Intake@roundlake.bc.ca

APPLICATION CHECKLIST FOR REFERRAL WORKER

All applications must review Appendix A; 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 client 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 Oat Therapy Contract?

If the Applicant is receiving Income Assistance, have you competed APPENDIX E?

- ☐ Forwarded the Form 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?

APPLICANT CHECKLIST

- ☐ I have recently completed a treatment program at _____and am clean from drugs and/or alcohol for ____ number of days or months____.
- ☐ I have return travel arrangements and am prepared to absorb the costs if I choose to leave the Recovery Home Program early or am discharged.
- ☐ I am willing to contribute to community living, participate in my relapse prevention program and my transition plans to ensure I increase my successful re-integration back into community.
- ☐ I have read, understand and accept the Painted Turtle Lodge 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 first two months of my stay at the recovery home.
- ☐ I have a bank card, identification (for cashing cheques) or the ability to obtain during my stay.
- ☐ I have read the What To Bring List and What Not To Bring List
- ☐ I have ensured that all necessary documents are included in the application.

200 Emery Louis Road, Armstrong, BC V4Y 0X3 Phone: 250-546-8848 / Fax: 250-546-3227
www.roundlaketreatmentcentre.ca Email: Intake@roundlake.bc.ca

GENERAL INFORMATION FOR APPLICANT

WHAT TO BRING

- Shampoo, soap, tooth brush, shaving kit, etc.
- Gym shoes (non-marking) and workout clothes
- Indoor non-marking shoes or slippers
- 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 blister packaged for the first two weeks of your stay.
- Over-the-counter medication and vitamins in the original packaging
- Debit and/or credit card
- Long distance calling card or private cell phone
- Enough cigarettes for the first two weeks and sufficient funds to purchase locally
- Personal health care number or Care Card (Canadian residents) and other valid identifications (PHOTO ID)
- Personal Laptop, please note that wifi is not available.
- Personal music devices, headphones required.

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
- Junk food
- Protein powders or workout supplements
- Sex toys
- 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.

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PAINTED TURTLE LODGE 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. Exceptions will be considered for emergency calls, with cell phone on vibrate and respectful notice given to facilitator.
- No cell phone usage is permitted during group activities with treatment center clients and we strongly discourage the sharing of cell phone devices with other residents.
- You will be able to check for mail after 4:00 p.m. at the Recovery Home Office or Administration 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

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- All medication will be turned in to the Resident Nurse 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, eg: 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. Vehicle access is subject your progress in recovery, please note that your vehicle keys may be taken away if suspicion of relapse and drinking and driving seem inevitable.
- Residents are not to sell items to each other or to staff.
- **Personal bedding, including blankets, pillows, cushions, and stuffed items are NOT permitted.**
- Treatment center clients are not permitted in the Recovery Home and Recovery Home Residents are not permitted in the Treatment Residence.

Visitors and Passes

- Visitors are only allowed to visit Recovery Home Residents with staff approval and requests must be in prior to staff exit on Friday afternoons.
- Preferred arrangement for visits and visitors are to be made off-site in the community.
- No visitors are permitted in the Painted Turtle Lodge.
- 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.
- **Day passes** are available after the first two completed months of living at the Painted Turtle Lodge.
- **Weekend passes** may be granted after the second month of residence, as long you're working your recovery program and signs of relapse are not inevitable.

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- **Holiday passes** are not recommended until after the first two-three months of residence and completion of the Relapse Prevention Program. Holiday passes are granted based on purpose, destination and personal strength in your recovery.

Communal Living Essentials

- Willingness to actively participate in assigned household chores, group activities and programming.
- Assist in keeping all areas of use/common areas clean, tidy and well maintained.
- Respectful regard and communication for one another and of differences, diversity, differing levels of an individual's stage in recovery.
- Hours of curfew to be respected and as it provides safety and 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, respect and kindness in all resident group activities and interactions.

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 or drugs 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 the Painted Turtle Lodge and 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.