



# Round Lake Treatment Centre (RLTC)

200 Emery Louis Road, Armstrong, BC V4Y 0X3

[www.roundlaketreatmentcentre.ca](http://www.roundlaketreatmentcentre.ca)

# Application Package

Phone: 250-546-8848 / Fax: 250-546-3227

Email: [Intake@roundlake.bc.ca](mailto: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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER _____	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED			
BAND OR TREATY MEMBER <input type="checkbox"/> YES <input type="checkbox"/> NO	ABORIGINAL ANCESTRY <input type="checkbox"/> INUIT <input type="checkbox"/> MÉTIS <input type="checkbox"/> NON-STATUS <input type="checkbox"/> N/A BAND OR TREATY NAME:		ON RESERVE <input type="checkbox"/> YES <input type="checkbox"/> NO
STATUS NUMBER <input type="checkbox"/> N/A	SOCIAL INSURANCE NUMBER		CARE CARD NUMBER
HOW IS TREATMENT PAID? Funding resources must be in place for confirmation to attend is sent. <input type="checkbox"/> FNIHB <input type="checkbox"/> MEIA <input type="checkbox"/> SELF <input type="checkbox"/> BAND			CLIENT TRAVEL WILL BE PAID <b>TO &amp; FROM</b> RLTC? <input type="checkbox"/> SELF <input type="checkbox"/> BAND <input type="checkbox"/> OTHER: _____
EMERGENCY CONTACT <sup>1</sup>	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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHAT KIND OF HEALING SUPPORTS HAS THE APPLICANT HAD IN LAST 3 MONTHS?		
<b>SOCIAL SUPPORT SYSTEM</b> HAS THE APPLICANT EVER ATTENDED:		
ALCOHOLICS ANONYMOUS	<input type="checkbox"/> ATTENDED <input type="checkbox"/> NOT ATTENDED	<input type="checkbox"/> WILLING TO ATTEND   _____ # ATTENDED
NARCOTICS ANONYMOUS	<input type="checkbox"/> ATTENDED <input type="checkbox"/> NOT ATTENDED	<input type="checkbox"/> WILLING TO ATTEND   _____ # ATTENDED
12 STEP PROGRAM	<input type="checkbox"/> ATTENDED <input type="checkbox"/> NOT ATTENDED	<input type="checkbox"/> WILLING TO ATTEND   _____ # ATTENDED
OTHER _____	<input type="checkbox"/> ATTENDED <input type="checkbox"/> NOT ATTENDED	<input type="checkbox"/> WILLING TO ATTEND   _____ # ATTENDED
LIST ALL AFTERCARE SUPPORTS AVAILABLE IN THE COMMUNITY (I.E. SUPPORT GROUPS, FAMILY/FRIENDS, FIRST NATIONS COMMUNITY, ELDERS)		
DOES THE APPLICANT HAVE A POST-TREATMENT APPOINTMENT SET? <input type="checkbox"/> YES <input type="checkbox"/> NO   IF YES, DATE OF APPOINTMENT: _____		

APPLICANT NAME	DATE OF BIRTH
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WHAT HAVE YOU DISCUSSED FOR AFTERCARE PLANS AND COMING BACK INTO THE COMMUNITY AND HOME?

WHAT ISSUES HAS THE PERSON/APPLICANT 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 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

WILL THE APPLICANT REQUIRE ASSISTANCE WITH READING/WRITING? <sup>1</sup>  
 YES   
 NO   
WHAT LEVEL OF LITERACY DOES THE APPLICANT READ OR WRITE AT?  
 Low   
 Medium   
 High

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 <sup>2</sup>   
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 INITIALS** \_\_\_\_\_   
 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:

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

<sup>2</sup> 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
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**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 persons 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.

**PART 5 – FAMILY AND LIVING ARRANGEMENTS**

**FAMILY STATUS** APPLICANT CURRENTLY IS:

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

IS SECURE CHILD CARE IN PLACE 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 APPLICANT BEEN MANDATED TO TREATMENT BY MCFD?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IS A SOCIAL WORKER CURRENTLY INVOLVED WITH THE FAMILY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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IS THERE ANY SUPERVISION ORDER IN PLACE BY MCFD?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DOES THE APPLICANT HAVE ANY NO-CONTACT ORDERS WITH HIS/HER SPOUSE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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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 <sup>3</sup>    SUICIDE IDEATION    SUICIDE ATTEMPTS <sup>4</sup>    SELF HARM TENDENCY    ANXIETY    MILITARY OR FIRST RESPONDER PTSD

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? <input type="checkbox"/> YES IF YES –TYPE OF HARM: _____ <input type="checkbox"/> NO
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HAS THE APPLICANT EVER BEEN PROFESSIONALLY ASSESSED BY A PSYCHOLOGIST OR PSYCHIATRIST? IF YES- SPECIFY<sup>5</sup> \_\_\_\_\_  
 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.)    FAMILY VIOLENCE ( ASSAULTS, BATTERY TRAUMA ~ )    HISTORY OF NEGLECT    WITNESSED AND / OR EXPERIENCED VIOLENCE    INDIAN RESIDENTIAL SCHOOL

PLEASE CLARIFY IN DETAIL ANY OF THE ABOVE:

<sup>3</sup> If FAS/FAE please provide results along with the date of testing.

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

<sup>5</sup> Provide dates and details and attach copy of **ALL** Psychological Assessments

APPLICANT NAME	DATE OF BIRTH
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DOES THE APPLICANT BELIEVE SOBRIETY IS NEEDED IN ORDER FOR LIFE TO CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	DOES THE APPLICANT HAVE ANY SPECIAL NEEDS WE NEED TO BE AWARE OF? IF YES- PLEASE SPECIFY. <input type="checkbox"/> YES <input type="checkbox"/> NO
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**PHYSICAL**

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

**SPIRITUAL**

IS THE APPLICANT WILLING TO PARTICIPATE IN FIRST NATIONS TREATMENT PROGRAM COMPONENTS SUCH AS SWEAT LODGE, DAILY SMUDGE, PIPE AND OTHER CULTURAL CEREMONIES? <sup>6</sup> <input type="checkbox"/> YES <input type="checkbox"/> 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 APPLICANT’S OWN WORDS, WHAT ARE THEIR PRESENTING PROBLEMS AND CHALLENGES? _____

<sup>6</sup> 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
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## PART 7 – APPLICANT SUBSTANCE USE HISTORY

### SUBSTANCE USE DISORDER HISTORY

**PLEASE PUT A CIRCLE AROUND THE PRIMARY SUBSTANCE 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)					
ILLCIT 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) ABSTINENT FROM ALL DRUGS AND ALCOHOL, MEDICAL MARIJUANA AND NON-APPROVED MEDICATION PRIOR TO ADMISSION. **NO EXCEPTIONS.** BASED UPON ASSESSMENT THE APPLICANT MAY BE ASKED TO PROVIDE URINE FOR SUBSTANCE USE TESTING UPON ADMISSION. IF TESTED POSITIVE HE/SHE WILL BE DECLINED ACCEPTANCE INTO THE PROGRAM.

**\*\*5 MONTHS ABSTINENCE FROM CRYSTAL METHAMPHETAMINE IS REQUIRED.**

**PLEASE REFER TO AND COMPLETE APPENDIX B ~MAST/DAST ASSESMENT**

APPLICANT NAME	DATE OF BIRTH
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## PART 8 – TREATMENT HISTORY

HAS THE APPLICANT ATTENDED RLTC BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DID THEY COMPLETE? <input type="checkbox"/> YES – DATE _____ <input type="checkbox"/> 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.				<input type="checkbox"/> YES <input type="checkbox"/> NO
2.				<input type="checkbox"/> YES <input type="checkbox"/> NO
3.				<input type="checkbox"/> YES <input type="checkbox"/> NO
4.				<input type="checkbox"/> YES <input type="checkbox"/> NO
IS THE APPLICANT APPLYING TO DO A REFRESHER? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, THEY 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	<input type="checkbox"/> METHADONE DOSE _____ (mg)	<input type="checkbox"/> SUBOXONE DOSE _____ (mg)
<b>NOTE: PLEASE REFER TO AND COMPLETE APPENDIX C ~ OAT MAINTENANCE PROGRAM</b>		

## 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? <sup>7</sup> <input type="checkbox"/> YES <input type="checkbox"/> 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.			

<sup>7</sup> 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 JAMIE'S PHARMACY 103-2802 30<sup>th</sup> ST. VERNON, BC V1T 8G7 FOR A SIX WEEK PROGRAM.**

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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 ADMISSION 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 SIGNATURE DATE

**NOTE:** The applicant may change or revoke this release at any time by giving notice to Round Lake Treatment Centre in writing. It is up to the applicant 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 VITAL SIGNS \_\_\_\_\_

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:		

PREGNANT?  YES  NO IF YES, WHAT TRIMESTER? \_\_\_\_\_ ANY PRIOR PROBLEMATIC PREGNANCIES? <sup>8</sup>

MUST HAVE DOCTORS CONSENT TO ATTEND

- 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.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<sup>8</sup> 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 that have had prior problematic or difficult pregnancy history.

APPLICANT NAME	DATE OF BIRTH
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**PART 10 – PHYSICIAN or NURSE PRACTITIONER’S REPORT (To be completed by Applicant’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?

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**AS A PRE-REQUISITE TO LIVING IN A RESIDENTIAL COMMUNITY TREATMENT SETTING, THE PATIENT MUST:**

- BE FREE FROM ALL COMMUNICABLE DISEASES AND ACUTE INFECTIOUS TRANSMISSIBLE  YES  NO
- HAVE A TB TEST IN THE LAST 12 MONTHS (**ATTACH RESULTS**)  POS  NEG DATE: \_\_\_\_\_

NOTE: IF THE MANTOUX TEST IS POSITIVE, A CHEST XRAY MUST BE ARRANGED AND RESULTS OF THE XRAY MAY TAKE UP TO 6 WEEKS.

- **HAVE TWO (2) WEEKS SUBSTANCE FREE FROM ALL DRUGS AND ALCOHOL, MEDICINAL MARIJUANA AND PRESCRIPTION DRUGS FROM THE UNSAFE MEDICATIONS LIST PRIOR TO ADMISSION TO ROUND LAKE TREATMENT CENTRE.**
- **FIVE (5) MONTHS ABSTINENCE IS REQUIRED FROM CRYSTAL METHAMPHETAMINE. NO EXCEPTIONS**

<b>PHYSICIAN / NURSE PRACTITIONER NAME</b>	<b>OFFICE STAMP</b>
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
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**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 is on Opioid Agonist 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 Opioid Agonist Therapy APPENDIX C MUST BE COMPLETED.** Check appropriate box to submit.

- Completed and sent a signed copy of the Applicant's OAT Maintenance Program Contract Form?

**If the Applicant is receiving Income Assistance, have you completed APPENDIX E & G~** Confirmation of Per Diem Funding/and or Comfort Allowance Form and Confirmation of Income Form

- Forwarded the Form to the Employment and Income Assistance worker to complete and sign?
- Forwarded Confirmation of Income Form (Ministry of Social Development and Poverty Reduction Form) to the Employment and Income Assistance worker to complete and 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 2 weeks abstinence from alcohol, drugs, medical marijuana and medication on the unsafe list or non-approved medications. **FIVE (5) MONTHS ABSTINENCE FROM CRYSTAL METHAMPHETAMINE. 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 eight-week treatment program.
- I have a bank card, and photo identification (for cashing cheques and travel).



## GENERAL INFORMATION FOR CLIENT

### WHAT TO BRING

- Shampoo, soap, toothbrush, toothpaste, shaving kit, all necessary toiletries, etc.
- Gym shoes (non-marking) and workout clothes
- Comfortable modest clothing is required
- Socks and underwear
- Modest Sweat Attire
- 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 (Including Photo ID for traveling purposes)

### 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 will need funds for medications they require during treatment if not covered by medical; may want to have some spending money when on outings, 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.