



Application for Admission

Application Requirements

1. Application form completed and signed by client.
2. Referring person (if applicable) complete page 9. – See Page 9 for referral requirements.
3. Medical physician must complete, sign and stamp the medical assessment on pages 10-12.

Admission Criteria

1. All legal, medical, education, employment, and child care services must be dealt with prior to admission so as not to interfere with your treatment program.
2. Remain alcohol and drug free for a minimum of 72 hours (3 days) prior to date of admission.

Financial Requirements

1. Alberta clients: (must provide a current and valid Alberta Health Care number on the application form): Treatment service charge of \$40 per day. Must have an agency providing funding confirmation OR if self paying, payment for the full the Tuesday prior to admission for treatment.
2. For clients outside Alberta: Treatment service charge of \$150 per day. Must have an agency providing funding confirmation OR if self paying, payment for the full amount the Tuesday prior to admission for treatment.
3. For clients outside of Canada: Treatment service charge of \$250 per day. Must have an agency providing funding confirmation OR if self paying, payment for the full amount the Tuesday prior to admission for treatment.

Return all 13 pages by mail, email to admissions@poundmaker.org or by fax to our Admissions department at fax 780-459-1876. Omitted information, incomplete or illegible answers may delay your admission.

What Program Are you Applying For? (Please only check one box)			
<input type="checkbox"/> 42 Day Drug/Alcohol Program		<input type="checkbox"/> 42 Day Gambling Program	
<input type="checkbox"/> 14 Day Follow up Program*		<input type="checkbox"/> Iskwew Healing Lodge	
* Must have previously completed a residential treatment program and have maintained sobriety since completion.			
Applications for the 90-Day Young Adult Treatment Program are processed through Alberta Health Services. Please call and speak with an Admissions Coordinator for more information.			
Legal Name (last, first, middle)			
Other Name(s) Used:		Other Last Name Used:	
Date of Birth (yyyy-mm-dd)	Health Care Number	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender



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Mailing Address:	City/Town:
Province:	Postal Code:
Primary Phone:	Secondary Phone:
Email:	
Marital Status (Please check one box only): <input type="checkbox"/> Single/Never married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Ethnicity <input type="checkbox"/> Status <input type="checkbox"/> Métis <input type="checkbox"/> Non-Aboriginal <input type="checkbox"/> Non-status <input type="checkbox"/> Inuit	
Treaty Status (if applicable): <input type="checkbox"/> Status <input type="checkbox"/> Métis Band Name: _____ 10 digit Treaty number: _____	
Residence <input type="checkbox"/> On reserve <input type="checkbox"/> Off reserve	
Education level achieved: (Please check one box only) <input type="checkbox"/> 1-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10-12 <input type="checkbox"/> Completed Grade 12 <input type="checkbox"/> Some Post Secondary <input type="checkbox"/> College Diploma/Degree <input type="checkbox"/> University Degree	Occupation: (Please check one box only) <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Not In labour Force <input type="checkbox"/> Student <input type="checkbox"/> Student <input type="checkbox"/> Retired
Next of Kin to be notified in case of emergency	Relationship to applicant
Primary Phone Number:	Secondary Phone Number:
If prescriptions or ambulance services are required, how will they be paid for? (Alberta Works, AISH, Blue Cross, Health Canada, etc?)	
Benefits Provider:	Provider Number:



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Legal Matters

* All legal matters must be dealt with prior to admission so as not to interfere with your treatment.

* All legal documents must be submitted along with application form.

Please check off any conditions that apply and complete section below. *(Please submit any legal orders)*

Federal

Parole Statutory Release

Provincial

Probation Recognizance Conditional Sentencing Order Temporary Absence

Type of Offence	Name of Parole/Probation Officer
Parole/Probation Officer's Phone	Parole/Probation Officer's Agency/Office

If you have a history of criminal convictions, list the type and approximate dates of conviction(s)

Please list any recent charges from the past year. (We may require supporting documentation)



Would you be coming to treatment under one of the following conditions?

Child Welfare Employment Reasons



Are there other concerns you feel we should know?



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Please describe in detail your alcohol, other drug use and/or gambling

What Substance are you wanting to seek treatment for?
What do you use most often?
Pattern of use (eg. daily, binge)
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? (yyyy-mm-dd):
Other Substance Used
What other substance do you use?
Pattern of use (eg. daily, binge)
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? (yyyy-mm-dd)
Other Substance Used
What other substance do you use?
Pattern of use (eg. daily, binge)
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? (yyyy-mm-dd)
Other Addiction Concerns:
<input type="checkbox"/> Video games/TV <input type="checkbox"/> Sex/Pornography <input type="checkbox"/> Food <input type="checkbox"/> Shopping <input type="checkbox"/> Relationships <input type="checkbox"/> Other _____
Gambling
Types of gambling done? (VLT, Bingo, Lottery)
Pattern of gambling (e.g. daily, weekends, payday)
Amount of money gambled per occasion



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How long have you gambled?
How long has this been a problem for you?
Date you last gambled (yyyy-mmm-dd):
Treatment history for alcohol, drug or gambling problems
Have you previously attended a treatment centre for addictions and/or gambling? And if so, which one(s) and when?
Reason(s) for previous treatment
Approximate date(s)
How long did you remain, alcohol, drug or gambling free after treatment?
Describe in detail how your drinking, drug taking and/or gambling affected you and your life? (<i>e.g. effects on family, relationships, employment, health, social life, etc.</i>)

What are your reasons for wanting to attend residential treatment at this time?

What are the most important areas for you to address while in treatment?



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Do you have any special needs or problems that we need to be aware of? (*reading and writing English, wheelchair accessibility, hearing difficulties, problem with stairs and long corridors*)

- No
 Yes, give details

Are you seeing a doctor regularly for any reason, including refilling medication?

- No
 Yes, explain

Describe current medical problems (e.g. chronic health issues, recent surgery, injuries, pain, etc.)

Have you been Hospitalized in the past 12 months?

- No
 Yes, explain

Have you ever experienced mental health concerns? (*e.g. panic attacks, hallucinations/delusions, uncontrollable rage, mood swings, mental illness, etc.*)

- No
 Yes, what are the problems?

Describe in detail how the above problems affected you or others both in the past and currently



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Have you had any thoughts of suicide or self harm?

- No
 Yes, describe in detail

Have you attempted suicide?

- No
 Yes, describe in detail

If currently under the care of a Doctor/Psychiatrist/Psychologist, complete the following boxes below:

Name:	Phone Number:	<input type="checkbox"/> Doctor <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist
Name:	Phone Number:	<input type="checkbox"/> Doctor <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist
Name:	Phone Number:	<input type="checkbox"/> Doctor <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist

Check method of payment:

- Cash** **Certified Cheque** **Money Order** **Visa** **Mastercard**

- SFI/ AB Works/ AISH** (Assured Income for Severely Handicapped)

If checked, provide 3rd party contact information

Name: _____ Organization: _____

Phone Number: _____ Fax Number: _____

Alberta Works or AISH File Number: _____

- Health Canada/ NNADAP**

If checked, provide 3rd party contact information

Name: _____ Organization: _____

Phone Number: _____ Fax Number: _____

- Other** (explain, ex Labour Unions) _____

If checked, provide 3rd party contact information

Name: _____ Organization: _____

Phone Number: _____ Fax Number: _____



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Carefully Read the Following:

- I understand in order to be admitted to residential treatment, I must remain alcohol and drug free for at least 72 hours (3 days) prior to my admission date. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be referred to a detoxification setting before treatment.
- I understand Poundmaker's Lodge is not responsible for personal costs I may incur (eg. approved medications) while I am in treatment.
- I understand I cannot schedule any appointments (legal, dental, medical, or personal) for the period while in treatment. I must focus on my treatment program.
- I understand and agree to accept and attend all components of the treatment program as prescribed by Poundmaker's Lodge including all lectures, 12 step meetings leisure and group counseling sessions

Signature	Date (yyyy-mm-dd)
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Waiver to Release Information

I, _____ authorize any professionals listed on this application (Referrals, Medical Staff, Probation Officers) to release to Poundmaker's Lodge Treatment Centres any information, including but not limited to, medical diagnosis, psychological and/or psychiatric assessments, evaluations and legal matter pertaining to my treatment at the aforementioned centre.

Signature	Date (yyyy-mm-dd)
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Authorization to Transfer Prescriptions

I, _____ authorize Poundmaker's Lodge to transfer my prescriptions from my current pharmacy to Pharmacare Pharmacy, Poundmaker's Lodge pharmacy in Edmonton, for the duration of my stay at Poundmaker's Lodge. I will bring a 2 day supply of my medications with me and will be provided with the remained of medications by Poundmaker's Lodge.

Signature	Date (yyyy-mm-dd)
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Application Checklist

- Completed application forms answering all questions and including 3 signatures on page 8
- Complete referral information on page 9
- Include copy of legal documents if you have had recent charges, legal orders, or upcoming court or legal matters
- Completed medical portion of application form, including physician signature, stamp, and any restricted medication documentation
- Confirmation of funding- who will pay for my treatment?



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Please note that all referrals must be on a professional basis; referrals from friends and family are not accepted.

Referral guidelines:

The referral will be the contact person for the applicant.

The referral will assist with setting up funding and travel (if necessary) for the applicant.

The referral will receive a Treatment Summary Report once the client has complete treatment.

Self-Referral, skip this section

This section is to be completed by the referring person only			
Referring Person's Name			
Agency		Professional relationship to applicant	
Business Address		City	Province
Postal Code	Email	Phone Number	Fax Number
Type of Referral (<i>check the box which most applies</i>) <input type="checkbox"/> AHS Addiction Services <input type="checkbox"/> Health/Medical- Doctor Business/Workplace, specifically: <input type="checkbox"/> Other Addictions Agency <input type="checkbox"/> Health/Medical- Other <input type="checkbox"/> EAP <input type="checkbox"/> Human Resources <input type="checkbox"/> Mental Health <input type="checkbox"/> WCB/ Disability Management <input type="checkbox"/> Other: _____ <input type="checkbox"/> Justice/legal <input type="checkbox"/> Private Employer			
What is your assessment of the applicant's readiness and motivation for residential treatment? _____ _____ _____ _____			
Other than alcohol, drug or gambling, what issues does the applicant need to address while in the program? _____ _____ _____ _____			
Referral's Signature		Date (yyyy-mm-dd)	
Client's Signature		Date (yyyy-mm-dd)	



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This medical assessment is required as part of the application and must be completed in full by a medical doctor.

***Please note: We will not accept medical applications without the clients name, date or birth or health card number.**

Patient Name (last, first, initial)		Date of Birth (yyyy-mm-dd)		Personal Health Care Number		
Allergies (eg. drug, food, latex, other)			Special Dietary Requirements			
Review of Systems (please send relevant reports, eg. CBC, hepatic profile, electrolytes, urinalysis, etc)						
EENT						
Respiratory (eg. asthma, COPD)			Cardiovascular (eg. CVA, MI, HTN, arrhythmia, pacemaker)			
Gastrointestinal (eg. GERD, history GI bleed, hepatitis, pancreatitis)			Genitourinary (eg. incontinence, BPH, STD)			
Musculoskeletal (eg. chronic pain, RA, OA, gout)			Integumentary (eg. psoriasis, eczema)			
Neurological Does the patient have a history of seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes			Hematological/Immune (eg. HIV+, HCV+)			
Evidence of withdrawal or intoxication? (eg. ETHO, OPIOID)			Other (specify)			
Physical Examination						
Height	Weight	Temperature	Pupils	Heart rate	Blood Pressure	Respiration rate
Skin		Diaphoresis		Tremor		
Is the patient diabetic? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete this information →			Year Diagnosed	Is the patient stable? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Does the patient have MRSA and wound? <input type="checkbox"/> No <input type="checkbox"/> Yes, (specify latest swab results) _____			Is there cognitive impairment? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Needs assistance ambulating or providing self care? <input type="checkbox"/> No <input type="checkbox"/> Yes						
When was the patient's last PAP smear?			What were the results?			
Pregnancy						
Is the patient pregnant? <input type="checkbox"/> No, complete top boxes only → <input type="checkbox"/> Yes, complete all boxes		LMP		Para		Gravida
		EDC	Urine hCG	Prenatal blood work	Prenatal ultrasound	Blood type
Does the patient have current pregnancy complications or had a history of pregnancy complications? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____						
Physician managing the pregnancy and delivery			Phone:		Fax:	



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Address of planned location of delivery			
Patient Name (last, first, initial)	Date of birth (yyyy-mm-dd)	PHN	
TB Screening- Symptoms and History			
Check the appropriate boxes			No
			Yes
Presence of cough lasting more than 2 weeks			
Weight loss, if yes specify ____ lbs. in ____ length of time			
Night sweats			
Fever			
Fatigue			
Haemoptysis (blood in sputum)			
Previous active TB and treatment			
Previous significant Mantoux or chest x-ray results			
Extensive travel (or birth) in a country with high incidence of TB			
Other risk factors (i.e. aboriginal, elderly, homeless, health care worker)			
Poor general health status and risk factors for progress of disease			
Further TB screening/assessment required- if yes, please send results			
Medical Approval			
In your opinion is this patient medically stable and appropriate for admission to Residential Addiction Treatment?			
<input type="checkbox"/> No <input type="checkbox"/> Yes			
Physician's Name	Signature	Date (yyyy, mmm, dd)	
Psychiatric Review/ History (send psychiatric evaluations and/or discharge summaries (if available))			
Addictions- note date of last use, pattern of abuse and severity of addiction (e.g. alcohol, cocaine, opioids, cannabis, gambling, tobacco, etc.)			
Primary	Secondary	Tertiary	
Is there evidence of the following? (please include your judgement related to current severity of mental health concerns)			
	No	Yes	Comments
Mental development and/or learning disorders? (e.g. depression, anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)			
Underlying pervasive or personality conditions			
Acute medical conditions and physical disorders aggravating mental health (e.g. brain injury, cognitive impairment, chronic pain, insomnia)			
Contributing psychosocial and environmental factors			
Global Assessment of Functioning			
Is there a history of self-harm, suicidal thoughts or suicide attempts? (If yes, pertinent psychiatric reports/assessments are required)			
Psychological Approval			
In your opinion is this patient medically stable and appropriate for admission to Residential Addiction Treatment?			
<input type="checkbox"/> No <input type="checkbox"/> Yes			



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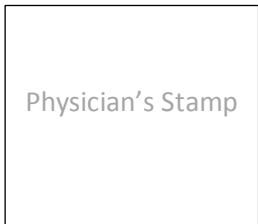
Physician's Name			Signature			Date (yyyy-mmm-dd)		
Patient Name (last, first, initial)			Date of birth (yyyy-mmm-dd)			PHN		
<p>At Poundmaker's Lodge Treatment Centres, we have a restricted medication list which indicates medications we do not allow the clients to enter treatment with. We ask the physician if there is an alternative medication the patient can be taking and if not; please include a note as to which medication the patient will be taking and why an alternative cannot be given.</p>								
Medications (if more room is needed, attach list)								
Medication	Dose	Route	Frequency	Reason given	Start Date	End Date	Prescribed By	Phone Number

Please remind patient that in order to be admitted to Poundmaker's Lodge, they need to:

- Be well enough to participate in the program and remain alcohol and drug free for at least 72 hours prior to Admission.
- Ensure any new medications not listed above have been pre-approved by the Admissions department.
- If the patient's medical or psychological condition changes before their scheduled admission date they must contact the Admissions department.

Physician's Name			Signature			Date (yyyy-mmm-dd)			
Mailing Address									
City/Town			Province		Postal Code		Phone		Fax
Primary Physician's Name (if different than above)						Phone		Fax	
Other (e.g. psychiatrist or other specialist relevant to this admission)						Phone		Fax	

***Please ensure the medical portion is signed and stamped by the medical physician who completed the forms. Failure to do so may cause delays in processing your application.**





Application for Admission

What types of medications are restricted at Poundmaker's Lodge Treatment Centres?

The following medications are restricted:

<p>Opioid Pain Medications</p> <ul style="list-style-type: none"> • Codeine & Codeine containing products (e.g. Tylenol #3) • Morphine (eg. <i>Kadian</i>) • Fentanyl • Hydromorphone (<i>Dilaudid</i>) • Oxycodone (<i>Percocet, OxyNeo</i>) • Methadone (<i>Metadol, Methadose</i>) • Meperidine (<i>Demerol</i>) • Tapentadol (<i>Nucynta</i>) • Tramadol (<i>Zytram, Ralivia, Tridural</i>) • Pentazocine (<i>Talwin</i>) • Propoxyphene (<i>Darvon</i>) • Buprenorphine (<i>BuTrans, Suboxone</i>) 	<p>Benzodiazepines</p> <ul style="list-style-type: none"> • Alprazolam (<i>Xanax</i>) • Bromazepam (<i>Lectopam</i>) • Lorazepam (<i>Ativan</i>) • Oxazepam (<i>Serax</i>) • Temazepam (<i>Restoril</i>) • Triazolam (<i>Halcion</i>) • Chlordiazepoxide (<i>Librium</i>) • Clonazepam (<i>Rivotril</i>) • Clorazepate (<i>Tranxene</i>) • Diazepam (<i>Valium</i>) • Flurazepam (<i>Dalmane</i>) • Nitrazepam (<i>Mogadon</i>)
<p>Psychostimulants</p> <ul style="list-style-type: none"> • Dextroamphetamine (<i>Dexedrine</i>) • Amphetamine Mixed Salts (<i>Adderall XR</i>) • Lisdexamfetamine (<i>Vyvanse</i>) • Methylphenidate (<i>Ritalin, Biphentin, Concerta</i>) • Modafinil (<i>Alertec</i>) 	<p>Miscellaneous</p> <ul style="list-style-type: none"> • Varenicline (<i>Champix</i>) • Nabilone (<i>Cesamet</i>) • Dronabinol (<i>Marinol</i>) • Medical Marijuana • Zopiclone (<i>Imovane</i>)

(Note: This list is not exhaustive and other medications may be subject to restriction)

What if I am taking Methadone or Suboxone for opioid dependence treatment?

Methadone and Suboxone will be accepted at Poundmaker's Lodge Treatment Centres only if your physician has indicated you are on a stable maintenance dose.

We suggest dosing prior to coming in on your admissions day to avoid any delay in receiving your medications.

We suggest 3 options if you are currently prescribed a restricted medication.

1. Discontinue the medication for the duration of your treatment program.
2. Ask your doctor for an alternative medication that is not on the restricted medication list.
3. If your doctor feels this is the best medication and there are no substitutions they can write a letter stating so.