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)

☐ **42 Day Drug/Alcohol Program** ☐ **42 Day Gambling Program** ☐ **Iskwew Healing Lodge****

☐ **14 Day Follow up Program***

* Must have previously completed a residential treatment program and have maintained sobriety since completion.

** Must complete the 42 day program or other treatment program prior to admission to the Woman's transitional house.

Applications for the 90-Day Young Adult Treatment Program are processed through Alberta Health Services.

Legal Last Name	Legal First Name	Middle Name

Other Name(s) Used:	Other Last Name Used:

Date of Birth (YYYY-MM-DD)	Health Care Number	Age	☐ Male ☐ Female ☐ Transgender

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Mailing Address:	City/Town:
Province:	Postal Code:
Primary Phone:	Secondary Phone:
If you do not have a phone where can we leave a message for you?	
Email Address:	

Marital Status (Please check one box only):

☐ Single/Never married ☐ Common Law ☐ Divorced

☐ Married ☐ Separated ☐ Widowed

Ethnicity

☐ Status ☐ Métis ☐ Non-Aboriginal

☐ Non-status ☐ Inuit

Treaty Status (if applicable):

☐ Status ☐ Métis

Band Name: _____ 10 digit Treaty number:_____

Residence

☐ On reserve ☐ Off reserve

Education level achieved: (Please check one box only) ☐ 1-6 ☐ 7-9 ☐ 10-12 ☐ Completed Grade 12 ☐ Some Post Secondary ☐ College Diploma/Degree ☐ University Degree	Occupation: (Please check one box only) ☐ Employed ☐ Unemployed ☐ Not In labour Force ☐ Student ☐ Student ☐ 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 (INAC), etc?)

Benefits Number (eg. AISH/Alberta Works File Number, Treaty Number, Blue Cross Benefits 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:		
☐ Video games/TV	☐ Sex/Pornography	☐ Food
☐ Shopping	☐ Relationships	☐ Other_____
Gambling		
Types of gambling done? (VLT, Bingo, Lottery)		
Pattern of gambling (e.g. daily, weekends, paydays)		

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Amount of money gambled per occasion
How long have you gambled?
How long has this been a problem for you?
Date you last gambled (YYYY-MM-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? *(e.g. effects on family, relationships, employment, health, social life, etc.)* _____ _____ _____ _____
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:	□ Doctor □ Psychiatrist □ Psychologist
Name:	Phone Number:	□ Doctor □ Psychiatrist □ Psychologist
Name:	Phone Number:	□ Doctor □ Psychiatrist □ 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 part 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)**

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)**

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)**

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 *(check the box which most applies)*

☐ AHS Addiction Services	☐Health/Medical- Doctor	Business/Workplace, specifically:
☐ Other Addictions Agency	☐ Health/Medical- Other	☐ EAP ☐ Human Resources
☐ Mental Health	☐ WCB/ Disability Management	☐ Other:_____
☐ Justice/legal	☐ 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 <u>completed in full by a medical doctor.</u>

***Please note: We will not accept medical applications without the <u>client's name, date of birth, and health card number.</u>**

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? □ No □ Yes	Hematological/Immune (eg. HIV+, HCV+)
Evidence of withdrawal or intoxication? (eg. ETOH, Opioid)	Other (specify)

Physical Examination

Height	Weight	Temperature	Pupils	Heart Rate	Blood Pressure	Respiration Rate

Skin	Diaphoresis	Tremor

Is the patient diabetic? ☐ No ☐ Yes, complete this information →	Year Diagnosed	Is the patient stable? ☐ No ☐ Yes

Does the patient have MRSA and wound? ☐ No ☐ Yes, (specify latest swab results) _____

Is there cognitive impairment? ☐ No ☐ Yes

Needs assistance ambulating or providing self care? ☐ No ☐Yes

When was the patient's last PAP smear?	What were the results?

Pregnancy

Is the patient pregnant? ☐ No, complete top boxes only → ☐ 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?

☐ No ☐ Yes, specify _____

Physician managing the pregnancy and delivery	Phone:	Fax:

Address of planned location of delivery

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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?

☐ No ☐ Yes

Physician's Name	**Signature**	**Date (YYYY-MM-DD)**

Psychiatric Review/ History (Please attach any 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?

☐ No ☐ Yes

Physician's Name	**Signature**	**Date (YYYY-MM-DD)**

Application for Admission

Patient Name (last, first, initial)	Date of birth (yyyy-mmm-dd)	PHN
At Poundmaker's Lodge Treatment Centres, we have a <u>restricted medication list</u> which indicates medications we do not allow the clients to enter treatment with. Please see the follow page for further details.		

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 <u>72 hours prior to Admission</u>.**
- **Ensure <u>any new medications</u> 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-MM-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 <u>signed and stamped</u> by the medical physician who completed the forms. Failure to do so may cause delays in processing your application.**

**** Please discuss any <u>restricted medication</u> at your initial appointment to avoid any delays in processing your application.**

Physician's Stamp

Application for Admission

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

The following medications are restricted:

Opiod Pain Medications • Codeine & Codeine containing products (e.g. Tylenol #3) • Morphine *(eg. Kadian)* • Fentanyl • Hydromorphone *(Dilaudid)* • Oxycodone *(Percocet, OxyNeo)* • Methadone *(Metadol, Methadose)* • Meperidine *(Demerol)* • Tapentadol *(Nucynta)* • Tramadol *(Zytram, Ralivia, Tridural)* • Pentazocine *(Talwin)* • Propoxyphene *(Darvon)* • Buprenorphine *(BuTrans, Suboxone)*	**Benzodiazepines** • Alprazolam *(Xanax)* • Bromazepam *(Lectopam)* • Lorazepam *(Ativan)* • Oxazepam *(Serax)* • Temazepam *(Restoril)* • Triazolam *(Halcion)* • Chlordiazepoxide *(Librium)* • Clonazepam *(Rivotril)* • Clorazepate *(Tranxene)* • Diazepam *(Valium)* • Flurazepam *(Dalmane)* • Nitrazepam *(Mogadon)*
Psychostimulants • Dextroamphetamine *(Dexedrine)* • Amphetamine Mixed Salts *(Adderall XR)* • Lisdexamfetamine *(Vyvanse)* • Methylphenidate *(Ritalin, Biphentin, Concerta)* • Modafinil *(Alertec)*	**Miscellaneous** • Varenicline *(Champix)* • Nabilone *(Cesamet)* • Dronabinol *(Marinol)* • Medical Marijuana • Zopiclone (Imovane)

(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.

What if I am currently on a restricted Medication?
We have 3 suggestions for restricted medications prior to admissions:

- You can discontinue the medication for the duration of your treatment. We suggest making a plan to taper off any medications and or to talk with your prescribing physician
- You can request an alternative medication that is not on the restricted medication list from your physician
- In the event the physician feels that there is no alternative to the medication, a medical note may be written by the physician stating their case.

The note from the physician must contain the following:

1. What the medication is used to treat
2. What dose the patient is on
3. What is the duration of use
4. Statement that there is no alternative
5. What happens when client is not on this medication
6. Statement that physician believes this medication would contribute to the client successfully completing Poundmaker's Lodge Programming or addiction treatment (it needs to specifically say addiction treatment or Poundmaker's)

*** Restricted medications are always on a case by case basis and must be approved by medical staff**