



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 10-13.

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 in 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"/> Iskwew Healing Lodge**
<input type="checkbox"/> 14 Day Follow up Program*			
* Must've previously completed Poundmaker's Lodge Treatment program and maintained sobriety since completion.			
** Must've completed 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. Call us for more info.			
Legal Last Name		Legal First Name	Middle Name
Other Name(s) Used First and Last:			
Date of Birth (YYYY-MM-DD)	Health Care Number	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female Other: _____



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Mailing Address: <input type="checkbox"/> No fixed address (please specify which city you reside in)	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): <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 Other: _____	
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	Employment status: (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:
Secondary next of kin to be notified	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 as to not interfere with your treatment *
 ** All legal documents must be submitted along with the application form **

Please check off any conditions that apply and complete section below	
<u>Federal</u>	
<input type="checkbox"/> Parole	<input type="checkbox"/> Statutory Release
<u>Provincial</u>	
<input type="checkbox"/> Probation	<input type="checkbox"/> Recognizance
<input type="checkbox"/> Conditional Sentencing Order	<input type="checkbox"/> 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 require supporting documentation)	

I, _____ confirm that I do not have any current legal matters before the courts or have any legal orders such as listed above. If this is to change during my wait period, I will update Poundmaker's Lodge with my current circumstances.	
Signature	Date (yyyy-mm-dd)
Would you be coming to treatment for Employment Reasons?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have Child Welfare involvement?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Worker's Name: _____ Contact: _____	



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

What Substance are you Seeking Treatment for?		
What do you use most often?		
Pattern of use (eg. daily, binge)	Route: (eg. IV, Oral, Intranasal, etc)	
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)	Route: (eg. IV, Oral, Intranasal, etc)	
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)	Route: (eg. IV, Oral, Intranasal, etc)	
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 _____



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Gambling
Types of gambling done? (VLT, Bingo, Lottery)
Pattern of gambling (eg. daily, weekends, paydays)
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?
1. 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>)

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

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



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4. 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

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

No

Yes, explain

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

7. Have you been hospitalized in the past 12 months?

No

Yes, explain

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

No

Yes, please specify?

9. Describe in detail how the above problems (question 8) have affected you or others in the past and/or currently



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10. Have you had any thoughts of suicide and/or have you self harmed?

- No
 Yes, describe in detail

11. 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 part contact information
 Name: _____ Organization: _____
 Phone Number: _____ Fax Number: _____
 Alberta Works or AISH File Number: _____
 Alberta Works Only – Please check one: Barriers to Full-Time Employment or Income Support

Health Canada/ NNADAP

If checked, provide 3rd party contact information
 Name: _____ Organization: _____
 Phone Number: _____ Fax Number: _____

Other (explain, ex Labour Unions, Insurance, GNWT, Homewood Health, etc)

 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 Ideal Care Pharmacy, Poundmaker's Lodge pharmacy in Edmonton, for the duration of my stay at Poundmaker's Lodge. I will bring a 3 day supply of my medications with me and will be provided with the remainder of my medications by Poundmaker's Lodge.

Signature	Date (YYYY-MM-DD)
------------------	--------------------------

Please note that we offer admissions on a first come first serve basis and *it is your responsibility to contact admissions after submitting the application to ensure it has been received*. Applicants will only be placed on the waitlist once we've received a completed application without any missing information or pages. Any missing information will result in delays. We require the following before you can be placed on the waitlist.

Application Checklist

- Completed application forms answering all questions 1 to 11 leaving no questions blank
- If you've had any recent charges, legal orders, upcoming court or legal matters (including Probation/Parole Officers name and contact information on page 3) and submit legal orders
- Confirmation of funding on page 7 (who will pay for my treatment)
- 3 signatures on page 8
- Complete referral information on page 9, if you are a self referral please check the box
- Completed medical portion of application form, including physician's signature and physician's stamp
- Restricted medication documentation, see page 13 for options (if applicable)

****Please note application expires after 6 months, and it is your responsibility to keep in contact****



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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, check the box and skip the section below

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	
<input type="checkbox"/> Other Addictions Agency		<input type="checkbox"/> Health/Medical- Other	
<input type="checkbox"/> Mental Health		<input type="checkbox"/> WCB/ Disability Management	
<input type="checkbox"/> Justice/legal		<input type="checkbox"/> Private Employer	
Business/Workplace, specifically:			
<input type="checkbox"/> EAP <input type="checkbox"/> Human Resources			
<input type="checkbox"/> Other: _____			
Readiness for change:			
<input type="checkbox"/> Pre-Contemplative <input type="checkbox"/> Contemplative <input type="checkbox"/> Preparation <input type="checkbox"/> Action <input type="checkbox"/> Maintenance <input type="checkbox"/> Relapse			
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?			

<input type="checkbox"/> Contact the referral for any missing information and to set an admission date			
<input type="checkbox"/> Contact the applicant for any missing information and to set an admission date			
<input type="checkbox"/> Send a copy of the Treatment Summary Report to the referral once treatment has been completed			
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 medicals without the client's name, date of birth, and 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. ETOH, 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:
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?			
<input type="checkbox"/> No <input type="checkbox"/> 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 psychologically stable and appropriate for admission to Residential Addiction Treatment?			
<input type="checkbox"/> No <input type="checkbox"/> Yes			
Physician's Name	Signature	Date (YYYY-MM-DD)	



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Patient Name (last, first, initial)			Date of birth (YYYY-MM-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 72 hours prior to Admission.
- Please discuss any restricted medication at your initial appointment to avoid any delays in processing your application
- Ensure any new medications not listed above have been pre-approved by the Admissions department
- If you plan to discontinue the medication we request so in writing
- If you receive an alternative medication we request a new prescription list
- 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 signed and stamped by the medical physician who completed the forms. Failure to do so may cause delays in processing your application.**

Physician's
Stamp



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The following medications are restricted at Poundmaker's Lodge:

<p>Opioid Pain Medications</p> <ul style="list-style-type: none"> • Codeine & Codeine containing products (e.g. Tylenol #3) • Morphine (<i>eg. Kadian</i>) • Fentanyl • Hydromorphone (<i>Dilaudid</i>) • Oxycodone (<i>Percocet, OxyNeo</i>) • Meperidine (<i>Demerol</i>) • Tapentadol (<i>Nucynta</i>) • Tramadol (<i>Zytram, Ralivia, Tridural</i>) • Pentazocine (<i>Talwin</i>) • Propoxyphene (<i>Darvon</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.

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 *****