Application for Admission

Application Requirements

1. Application form completed and signed by client.
2. Referring person 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 childcare 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): The Government of Alberta has committed to significant investment and changes to addiction treatment and recovery for Albertans. As part of the Government's work and realignment of funding envelopes, all publicly funded residential addiction treatment services are mandated to cease charging Albertans fees for access to publicly funded residential addiction treatment, effective Oct 01, 2020.
2. For clients outside Alberta: Treatment service charge of $205 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. Clients who arrive requiring Detox there is an additional charge of $300 per day for Medical Detox; the 42 day treatment program begins the day the individual is medically fit and is transitioned into programming.
3. For clients outside of Canada: Treatment service charge of $325 per day, additional charges are attached for Medical Detox. Must have an agency providing funding confirmation OR if self-paying, payment for the full amount the Tuesday prior to admission for treatment. * Refunds will be prorated

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?		
☐**42 Day Drug/Alcohol Program**	☐**42 Day Gambling Program**	☐**Iskwew Healing Lodge****
☐**14 Day Follow up Program***		
* Must have previously completed Poundmaker's Lodge Treatment program and have 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.		
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	☐Male
			☐Female
			☐Other:

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Mailing Address: ☐ 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):

☐ Single/Never married	☐Common Law	☐Divorced
☐ Married	☐Separated	☐Widowed

Ethnicity:

☐ Status	☐Métis	☐Non-Indigenous
☐ Non-Status	☐Inuit	☐Other:

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)			**Employment status: (please check one box only)**	
☐ 1-6	☐7-9	☐ 10-12	☐ Employed	☐ Unemployed
☐ Completed Grade 12	☐ Some Post-Secondary		☐ Not in Labor Force	☐ Student
☐ College Diploma/Degree	☐ University Degree		☐ Retired	

Next of Kin to be notified in case of emergency	Relationship to the Applicant
Primary Phone Number:	Secondary Phone Number:
Secondary next of kin to be notified	Relationship to the 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 (e.g.: 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****

Please check off any conditions that apply and complete the 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 of approximate dates of conviction(s)

_____
_____
_____

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

_____
_____
_____

I, _____confirm that I do not have any current legal matters before the courts for have any legal orders such as listed above. If this is to chance during my wait period, I will update Poundmaker's Lodge Treatment Centre's with my current circumstances.

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

Would you be coming to treatment for Employment Reasons?

☐ Yes	☐ No

Do you have Child Welfare involvement?

☐ Yes	☐ 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 (e.g.: daily, binge)	Route (e.g.: 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 (e.g.: daily, binge)	Route (e.g.: 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 (e.g.: daily, binge)	Route (e.g.: 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:		
☐ Video games/TV	☐ Sex/Pornography	☐ Food
☐ Shopping	☐ Relationships	☐ Other:

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Gambling
Types of gambling done? (VLT, Bingo, Lottery)
Pattern of gambling (e.g.: 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 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? *(e.g.: effects on family, relationships, employment, health, social life, etc.)*

_____
_____
_____
_____

2. What are your reason(s) 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, provide details:

_____

_____

_____

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

☐ No

☐ Yes, provide details:

_____

_____

_____

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, provide details:

_____

_____

_____

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

☐ No

☐ Yes, provide details:

_____

_____

_____

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

☐ No

☐ Yes, provide details:

_____

_____

_____

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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:	□Doctor □Psychiatrist □Psychologist
Name:	Phone Number:	□Doctor □Psychiatrist □Psychologist

Check method of payment				
☐ Cash	☐Certified Cheque	☐ Money Order	☐ Visa	☐ MasterCard

☐ **SFI / Alberta Works / AISH** (Assured Income for Severely Handicapped) If checked, provide 3rd party contract information	
Name:	Organization:
Phone Number:	Fax Number:
Alberta Works or AISH File Number:	
Alberta Works ONLY – Please provide one:	
☐ Barriers to Full-Time Employment	☐ Income Support

☐ **Health Canada / NNADAP** If checked, provide 3rd party contact information	
Name:	Organization:
Phone Number:	Fax Number:

☐ **Other** (example: Labor 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 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 (e.g. 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 Poundmaker's Pharmacy, in St. Albert, 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 Pharmacy, and I understand I am responsible for coverage/payment for my prescriptions.

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 to ensure your application has been received. Applicants will only be placed on the waitlist once we have 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 leaving no questions blank

☐ Include 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)

☐ Confirmation of funding on page 7 (who will pay for my treatment) if applicable

☐ 3 signatures on page 8

☐ Complete referral information on page 9

☐ 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, it is your responsibility to keep in contact.**

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

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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 completed treatment.

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: _____			
☐Other Addiction Agency	☐ Justice/Legal Counsel	☐EPA	☐Human Resources		
☐Mental Health Centre	☐WCB/Disability Management	☐Other: _____			
Readiness for change:					
☐Pre-Contemplative	☐Contemplative	☐Preparation	☐Action	☐Maintenance	☐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? _____ _____ _____					
☐Contact the referral for any missing information and to set an admission date					
☐Contact the applicant for any missing information and to set an admission date					
☐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)**				

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>**

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Patient Name (last, first, initial)	Date of Birth (YYYY-MM-DD)	Personal Health Care Number
Allergies (e.g.: drug, food, latex, other)	Special Dietary Requirements	

Review of Systems *(please send relevant reports, e.g.: CBC, Hepatic profile, electrolytes, urinalysis, etc.)*

EENT	
Respiratory (e.g.: asthma, COPD)	Cardiovascular (e.g.: CVA, MI, HTN, arrhythmia, pacemaker)
Gastrointestinal (e.g.: GERD, history of GI bleed, hepatitis, pancreatitis)	Genitourinary (e.g.: incontinence, BPH, STD)
Musculoskeletal (e.g.: chronic pain, RA, OA, gout)	Integumentary (e.g.: psoriasis, eczema)
Neurological: does the patient have history of seizures?	☐No ☐Yes
Hematological/Immune (e.g.: HIV+, HCV+)	Evidence of withdrawal or intoxication? (e.g.: 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	Year Diagnosed?	Is the patient stable?	☐ No	☐ Yes

Does the patient have MRSA and wound?	☐ No	☐ Yes, (specify latest swab result):
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 →	LMP		Para		Gravida
☐Yes, complete all boxes →	EDC	Urine HGC	Prenatal Blood Work	Prenatal ultrasound	Blood type

Does the patient have current pregnancy compilations or had a history of pregnancy complications?		
☐ No	☐ Yes, specify:	
Physician managing the pregnancy and delivery	Phone:	Fax:
Address of planned location of delivery:		

Patient Name (last, first, initial)	**Date of birth (YYYY-MM-DD)**	**PHN**

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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		
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 (e.g.: indigenous, 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 the 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 use your best judgment 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? □No □ Yes		
Physician's Name	Signature	Date (YYYY-MM-DD)

Patient Name (last, first, initial)	Date of Birth (YYYY-MM-DD)	PHN

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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. Please see the following 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 any medication(s) we request so in writing by your physician
- If you receive an alternative medication(s) 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.
- All current medications in their original containers with proper labels. NOTE: **Minimum of 2 days and maximum of 4 days' worth** – Upon arrival all prescriptions will be filled through Poundmaker's Pharmacy. The contact information to set up prescription transfer is 780-459-7963 (phone) and 780-459-9870 (fax). This MUST be completed prior to admission into Poundmaker's Lodge Treatment Centres.

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

The following medications are restricted at Poundmaker's Lodge Treatment Centre's:

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

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Opioid Pain Medications • Codeine & Codeine containing products (e.g. Tylenol #3) • Morphine (eg. Kadian) • Fentanyl • Hydromorphone (Dilaudid) • Oxycodone (Percocet, OxyNeo) • Meperidine (Demerol) • Tapentadol (Nucynta) • Tramadol (Zytram, Ralivia, Tridural) • Pentazocine (Talwin) • Propoxyphene (Darvon)	**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)

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:

- With physician guidance and supervision, you may be able to discontinue the medication for the duration of your treatment. We suggest making a plan with your physician to taper off any medications.
- You can request from your physician an alternative medication that is not on the restricted medication list.
- In the event the physician feels that there is no alternative to the medication, a medical note may be written by the physician stating the reasoning for the medication as well as the length of time on said medication(s).

The note from the physician must contain the following:

1. What the medication is used to treat,
2. What dosage the patient is on,
3. What the duration of use is,
4. Statement that there is no alternative medication,
5. What will happen 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 *****

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