



Application for Admission

Application Requirements

- Application form completed and signed by client.
- Referring person complete page 10 for referral requirements.
- Medical physician must complete, sign and stamp the medical assessment on pages 11-16.

Admission Criteria

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

Financial Requirements

- 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.
- For clients outside Alberta: Treatment service charge of \$305 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 \$350 per day for Medical Detox; the 42 day treatment program begins the day the individual is medically fit and is transitioned into programming.
- For clients outside of Canada: Treatment service charge of \$425 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 **17 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.



Application for 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*		
*Must've previously completed Poundmaker's Lodge Treatment program and maintained sobriety since completion.		
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	<input type="checkbox"/> Other:
Mailing Address:		City/Town:
<input type="checkbox"/> No fixed address - please specify which City you reside in:		
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-Indigenous
<input type="checkbox"/> Non-Status	<input type="checkbox"/> Inuit	<input type="checkbox"/> Other:
Treaty Status (if applicable)		
<input type="checkbox"/> Status	<input type="checkbox"/> Métis	
Band Name:		
10 Digit Treaty Number:		



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Residence				
<input type="checkbox"/> On Reserve			<input type="checkbox"/> Off Reserve	
Education level achieved: (please check one box only)			Employment status: (please check one box only)	
<input type="checkbox"/> 1-6	<input type="checkbox"/> 7-9	<input type="checkbox"/> 10-12	<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Completed Grade 12		<input type="checkbox"/> Some Post-Secondary	<input type="checkbox"/> Not in Labor Force	
<input type="checkbox"/> College Diploma/Degree		<input type="checkbox"/> University Degree	<input type="checkbox"/> Student	<input type="checkbox"/> 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? (Income Support, SAID, Personal Benefits, Health Canada (INAC), etc.?)				
Benefits Number (e.g.: SAID/Income Support file number, Treaty Number, Blue Cross)				
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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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. <i>(Please submit any legal orders)</i>				
Federal →	<input type="checkbox"/> Parole	<input type="checkbox"/> Statutory Release		
Provincial →	<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 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 or have any legal orders such as listed above. If this is to change during my wait period, I will update Battleford Addiction Treatment Centre with my current circumstances.				
Signature:			Date (YYYY-MM-DD)	



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Substance Use and Gambling History

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		
<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		



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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?
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 reason(s) for wanting to attend residential treatment at this time?
What are the most important areas for you to address while in treatment?
Do you have any special needs or problems that we need to be aware of? <i>(reading and writing English, wheelchair accessibility, hearing difficulties, problem with stairs and long corridors)</i>
<input type="checkbox"/> No <input type="checkbox"/> Yes, provide details:
Are you seeing a doctor regularly for any reason, including refilling medication?
<input type="checkbox"/> No <input type="checkbox"/> Yes, provide details:



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Describe current medical problems (e.g.: chronic health issues, recent surgery, injuries, pain, etc.)				
Have you been hospitalized in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes, provide details:				
Have you ever experienced mental health concerns? (e.g. panic attacks, hallucinations/delusions, uncontrollable rage, mood swings, mental illness, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, provide details:				
Describe in detail how the above problems affected you or others both in the past and currently <input type="checkbox"/> No <input type="checkbox"/> Yes, provide details:				
Have you had any thoughts of suicide and/or have you self-harmed? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe in detail:				
Have you attempted suicide? <input type="checkbox"/> No <input type="checkbox"/> 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		
Check method of payment				
<input type="checkbox"/> Cash	<input type="checkbox"/> Certified Cheque	<input type="checkbox"/> Money Order	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard
<input type="checkbox"/> SFI / Alberta Works / AISH (Assured Income for Severely Handicapped) If checked, provide 3rd party contract information				



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Name:	Organization:
Phone Number:	Fax Number:
Alberta Works or AISH File Number:	
Alberta Works ONLY – Please provide one:	
<input type="checkbox"/> Barriers to Full-Time Employment	<input type="checkbox"/> Income Support
<input type="checkbox"/> Health Canada / NNADAP	
If checked, provide 3rd party contact information	
Name:	Organization:
Phone Number:	Fax Number:
<input type="checkbox"/> Other (example: Labor Unions, Insurance, GNWT, Homewood Health, etc.)	
If checked, provide 3rd party contact information	
Name:	Organization:
Phone Number:	Fax Number:
Carefully Read the Following	
<ul style="list-style-type: none"> 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 Battleford Addiction Treatment Centre 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 Battleford Addiction Treatment Centre 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)

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.

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

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)



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Referral Requirements

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.

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)			
<input type="checkbox"/> AHS Addiction Services	<input type="checkbox"/> Health/Medical- Doctor	<input type="checkbox"/> Business/Workplace:	
<input type="checkbox"/> Other Addictions Agency	<input type="checkbox"/> Justice/legal	<input type="checkbox"/> EAP	
<input type="checkbox"/> Human Resources	<input type="checkbox"/> Mental Health Centre	<input type="checkbox"/> WCB/ Disability Management	
<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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Medical Assessment

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:				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:						



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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?		LMP		Para	
<input type="checkbox"/> No, complete all boxes →				Gravida	
<input type="checkbox"/> Yes, complete all boxes →		EDC	Urine HCG	Blood work	Ultrasound
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:					
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					



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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:	
<p>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.</p>	<p style="font-size: 24px; color: #ccc;">Physician's Stamp</p>	



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Restricted Medication

The following medications are restricted at Poundmaker's Lodge Treatment Centres. *This list is not exhaustive, and other medications may be subject to restriction:*

<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>)

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).



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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)