Alberta Health Services

Residential Adult Addiction Treatment Program Application

The applicant should complete pages one to five of this form and have the referring person *(if applicable)* complete page six.

The medical assessment on pages seven to nine must be completed by a medical doctor or nurse practitioner.

Return **all pages** by fax or by mail to the appropriate centre below. Unanswered questions, incomplete or illegible answers may delay your admission.

Check the centre you are applying for. **You may only select one.**

☐ **Northern Addictions Centre**
11333 - 106 Street
Grande Prairie, AB T8V 6T7
Phone: 780.538.6316 **Fax**: 780.538.6313

☐ **Fort McMurray Recovery Centre**
451 Sakitawaw Trail
Fort McMurray, AB T9H 4P3
Phone: 780.793.8300 **Fax**: 780-793-8301

☐ **Lander Treatment Centre**
P.O. Box 1330
221 Fairway Drive
Claresholm, AB T0L 0T0
Phone: 403.625.1395 **Fax**: 403.625.1300

☐ **Henwood Treatment Centre**
18750 18 Street NW
Edmonton, AB T5Y 6C1
Admissions: 780.422.4466
Switchboard: 780.422.9069 **Fax**: 780.422.5408

☐ **Medicine Hat Recovery Centre**
370 Kipling Street SE
Medicine Hat AB, T1A 1Y6
Phone: 403.529.9021 **Fax**: 403.529.9065

Legal name *(last, first, middle)*			
What name do you like to be called?		Other name *(e.g. maiden name or an alias)*	
Date of Birth *(yyyy-Mon-dd)*	Age	Alberta Health Care *(AHC)*	Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X)

Marital status *(Choose **one** only)*
☐ Single/Never married ☐ Married/Common-Law/Partnered ☐ Widowed
☐ Separated ☐ Divorced

Mailing Address			
City	Province	Postal Code	Primary Phone
Alternate Phone	Emergency Contact name	Emergency Relation	Emergency Phone

Three months ago, were you a resident of a province or territory other than Alberta?
☐ No
☐ Yes, what date did you take up residency in Alberta? (yyyy-Mon-dd) _____
(proof of Residency may be required)

What is your occupation?	Who is your employer?

If your application was prompted, check all that apply
☐ Addiction Services Office
☐ Child Welfare Worker
☐ Addiction Funded Agency
☐ Social Services/Income Support Worker
☐ AISH
☐ Physician
☐ Psychiatrist/Psychologist/Mental Health Worker
☐ Employer/Employee Assistance Program
☐ Court/Parole Office/Probation Officer/Lawyer
☐ Other *(specify)* _____

Describe in detail your alcohol, other drug use and/or gambling.

Regular Substance
What do you use most often?
Pattern of use *(e.g. daily, binge)*
How long have you used this substance?
How long has this been a concern for you?
Date you last used this substance? *(yyyy-Mon-dd)*
Other Substance Used
What other drug do you use?
Pattern of use *(e.g. daily, binge)*
How long have you used this substance?
How long has this been a concern for you?
Date you last used this substance? *(yyyy-Mon-dd)*
Other
What other drug have you used?
Pattern of use *(e.g. daily, binge)*
How long have you used this substance?
How long has this been a concern for you?
Date you last used this substance? *(yyyy-Mon-dd)*
Tobacco/Vaping
Do you use tobacco or vaping products? ☐ Yes ☐ No
All AHS sites are tobacco and vaping product free. Will you require nicotine replacement while you attend this site? *(note that you may be required to provide your own nicotine replacement products while on site)* ☐ Yes ☐ No
Gambling
Types of gambling done? *(e.g. VLT, bingo, horse gambling)*
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 concern for you?
Date you last gambled? *(yyyy-Mon-dd)*

Treatment history for alcohol, drug or gambling problems

Have you previously attended Alberta Health Services residential addictions treatment?

☐ No

☐ Yes, check all that you've attended below ▼

☐ Lander Treatment Centre ☐ Northern Addictions Centre ☐ Fort McMurray Recovery Centre

☐ Henwood Treatment Centre ☐ Medicine Hat Recovery Centre ☐ Business and Industry Clinic

Other treatment agencies attended

Reason(s) for previous treatment

Approximate date(s)

How long did you remain alcohol, drug or gambling free after treatment?

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

Describe in detail how your drinking, drug taking and/or gambling has affected you and your life? *(e.g. effects on family relationships, employment, health, social life, etc.)*

Other than alcohol, substances or gambling, what are other concerns that you may wish to address while in treatment?

Do you have any concerns or challenges that may require additional support while you attend residential treatment programming? *(e.g.reading and writing English, wheelchair accessibility, hearing difficulties, problems with stairs and long corridors)* ☐ No ☐ Yes, give details

Medical Details

Do you have any allergies? *(medications, foods, environmental)*

☐ No ☐ Yes, list allergies and common reactions for each

List all medications that you are taking, including all over-the-counter drugs. *(e.g. Gravol, Tylenol, NyQuil, allergy medications, vitamins, herbal remedies, etc.) Attach a sheet if needed*

Medication	Dose	Route	Frequency	Reason given	Start date	End date	Prescribed by	Phone number

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

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 concerns?_____

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

If currently under the care of a doctor/psychiatrist/psychologist, complete boxes below ▼

Name	Phone Number

Have you had any thoughts of suicide or self-harm?

☐ No ☐ Yes, describe in detail

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

Describe any outstanding or pending legal charges

If applicable, list upcoming court dates

Are you currently incarcerated/in jail?
☐ No
☐ Yes, which institution _____

Are you on Probation, Temporary Absence or Parole?
☐ No
☐ Yes, complete below ▼

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

Is there anything else you feel we should know?

Medication Payment

If you are on medications, how will you be paying for them?

☐ Alberta Blue Cross ☐ Other private insurance _____
☐ AISH ☐ Alberta Works ☐ FNIHB
☐ Any other provincially funded support program _____
☐ Self-Partial
☐ Cash ☐ Certified Cheque ☐ Money Order ☐ Visa ☐ Mastercard
☐ Self-Full
☐ Cash ☐ Certified Cheque ☐ Money Order ☐ Visa ☐ Mastercard
☐ Social Services,
If checked, provide 3rd party contact information _____
☐ Health Canada/Indian Affairs
If checked, provide 3rd party contact information _____
☐ Other *(explain)* _____
ensure you have file/policy numbers available to support medication payment if required

Carefully Read the Following

- I understand in order to be admitted to residential treatment, I **must** remain alcohol and drug free for at least five days *(length of time may vary based on assessment)* prior to my admission date, and be well enough to participate in the program. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be referred to an appropriate detoxification setting before treatment.
- I understand Alberta Health Services (AHS) is not responsible for my transportation or any other personal costs I may incur *(e.g. approved medications)* while I am in treatment. I will bring and give to staff all medications I am taking.
- 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 AHS, including all workshops, lectures, leisure and group counseling sessions.

Signature	Date *(yyyy-Mon-dd)*

The personal information collected by this application is collected under the authority of section 33(c) of the Freedom of Information and Protection of Privacy Act and section 20 of the Health Information Act and will be used and disclosed by AHS for verifying the statements in this application and for determining admission to Residential Adult Addictions Treatment Program. If you have questions about this program call one of the treatment centres. If you have any questions about AHS' privacy policies and practices, contact Information and Privacy at 1-877-476-9874. You may also write to Information and Privacy at 10301 Southport Lane SW, Calgary, Alberta T2W 1S7 or email us at privacy@albertahealthservices.ca

Alberta Health Services

Residential Adult Addiction Treatment Program Application

Note: you **cannot** self refer to the Northern Addictions Centre or Fort McMurray Recovery Centre. You must have a referring person to apply. All referrals must be on a professional basis; referrals from friends or family are not accepted.

☐ Self-referral, skip this section

This section is to be completed by the referring person only

Referring Person's Name			
Agency	Professional or Personal relationship to applicant		
Business Address	City		Province
Postal Code	Phone Number	Fax Number	

Type of Referral *(check the box which most applies)*

☐ AHS Addiction Services
☐ Other Addictions Agency
☐ Relative/Friend
☐ Pastoral
☐ WCB/Disability Management
☐ Other *(specify)* _____

☐ Health/Medical – Doctor
☐ Health/Medical - Other
☐ Mental Health
☐ Justice Legal

☐ Business/Workplace, specifically:
- ☐ EAP
- ☐ Human Resources
- ☐ Occupational Health
- ☐ 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-Mon-dd)*

Alberta Health Services

Residential Adult Addiction Treatment Program Application

This medical assessment is required as part of the application and must be completed in full by a medical doctor or nurse practitioner. The cost of fully completing this medical is covered by Alberta Health Care.

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	Alberta Health Care Number *(AHC)*
Allergies *(e.g.drug, food, medical tape, other)*		

Review of Systems *(send relevant reports, e.g. CBC, hepatic profile, electrolytes, urinalysis, fasting blood glucose)*

EENT	
Respiratory *(e.g. asthma, COPD)*	Cardiovascular *(e.g. CVA, MI, HTN, arrythmia, pacemaker)*
Gastrointestinal *(e.g. GERD, history GI bleed, hepatitis, pancreatitis)*	Genitourinary *(e.g. incontinence, BPH, STD)*
Musculoskeletal *(e.g. chronic pain, RA,OA, gout)*	Integumentary *(e.g. psoraiasis, eczema)*
Neurological Does the patient have a 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, complete this information ► *(need recent HbA1c result)*	Year diagnosed	Is the patient stable? ☐ No ☐ Yes
Is there cognitive impairment? ☐ No ☐ Yes	Does the patient have MRSA and wound? ☐ No ☐ Yes, *(specify latest swab results)*_____	
Needs assistance ambulating or providing self care? ☐ No ☐ Yes		

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		

Alberta Health Services

Residential Adult Addiction Treatment Program Application

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	Alberta Health Care Number *(AHC)*

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		
Increased risk factors *(i.e. Indigenous, elderly, homeless, health care worker)*		
Poor general health status and risk factors for progress of disease		
Further TB screening/assessment required -if **yes** send results to appropriate centre		

Medical Approval

In your opinion is this patient **medically stable** and appropriate for admission to Residential Addiction Treatment?
☐ No ☐ Yes

Physician or Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Psychiatric Review/History *(send psychiatric evaluations and/or discharge summaries if available)*

Addictions-note date of last use, pattern of abuse and severity of addiction *(e.g. alcohol, cocaine, opioids, cannabis, gambling, tobacco, etc.)*

Primary	Secondary	Tertiary

Is there evidence of the following? *(include your judgement related to current severity of mental health concerns)*

✔	**No**	**Yes**	**Comments**
Mental, developmental and/or learning disorders *(e.g. depression, anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)*			
Underlying pervasive or personality conditions *(e.g. personality disorders)*			
Acute medical conditions and physical disorders aggravating mental health *(e.g. brain injury, cognitive impairment, chronic pain, insomnia)*			
Contributing psychosocial and environmental factors.			
Disordered Eating			
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 or Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Alberta Health Services

Residential Adult Addiction Treatment Program Application

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	Alberta Health Care Number *(AHC)*

Medications *(if more room is needed, attach list. Send relevant laboratory results e.g. current INR, Lithium or Phenytoin levels)*

Medication	Dose	Route	Frequency	Reason given	Start date	End date	Prescribed by	Phone number

Remind patient that in order to be admitted to Residential Adult Addictions Treatment Program, they need to:

- Be well enough to participate in the program and remain **alcohol and drug free for at least five days prior** *(length of time may vary based on assessment)* to admission.
- Ensure any new medications not listed above have been pre-approved by Treatment Program nurse.
- Bring enough of their medications *(in the original packaging from the doctor or pharmacist)* for their time in treatment.
- If the patient's medical or psychological condition changes before their scheduled admission date they must contact the Treatment Program.

Physician/Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*
Mailing address		

City	Postal Code	Phone	Fax
Primary Physician Name *(if different than above)*		Phone	Fax
Other *(e.g. psychiatrist or other specialist relevant to this admission)*		Phone	Fax
Primary Care Network affiliation?	☐ No ☐ Yes, complete this information ▼		
Name		Address	

Physician Stamp