Alberta Health Services

Admission Application - Concurrent Disorders Program

- Fax the completed form to **403.625.3051** or mail to **Admissions Coordinator, Claresholm Centre for Mental Health & Addictions, PO Box 490, 139 - 43 Ave West, Claresholm, AB T0L 0T0**
- Please note, referrals will only be processed and considered once all requested documentation has been received. Thank you for your cooperation
- For further assistance or more information, please call **403.682.3527** or **403.682.3500**

Demographic Information			
Last Name	First Name	Middle	Date of Referral *(yyyy-Mon-dd)*
Gender ☐ Male ☐ Female	Date of Birth *(yyyy-Mon-dd)*	Provincial Health Care # *(If out of Alberta, please specify Province)*	
Marital Status ☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed			
Home Address	City	Province	Postal Code
Phone # *(Home)*	Phone # *(Work)*	Cell #	
Fax #	Can messages be left at these numbers? ☐ No ☐ Yes		
Physician of Record		Office Phone #	
Specialist of Record		Office Phone #	
Emergency Contact	Phone *(Home)*	Alternate Phone	

Current Medical and Psychiatric Status

Is client currently hospitalized? ☐ No ☐ Yes ► Where _____

Most recent Psychiatric Assessment (within 1 year) must be included, in order for the application to be processed.

DSM5 Diagnosis

_____

_____

_____

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Please indicate any barriers that would delay or prevent client from attending residential treatment for a minimum of six weeks

Acute Medical Condition(s)

☐ No ☐ Yes ► Please specify and attach most recent medical investigation results and reports

Allergies

☐ No ☐ Yes ► Please specify

Medications

☐ Printout of medication and dosage *(attach)* if not, please list all medications below

Current medications and herbal remedies *(if space provided is inadequate, please add a sheet at the end of this form)*

Previous Medication

Goal of Care Designation

Blood Work

Please note, the Concurrent Disorders Program at CCMHA requires the following blood work to be current values *(within six months)*. Please include the following results

☐ CBC with differential ☐ Liver Function Test ☐ TSH ☐ Therapeutic Medication Levels *(as appropriate)*

Addiction Profile

Current substance(s) of Choice	Amount and Frequency of Use	Duration Use

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Periods of Sobriety

Substance(s) Abstained	Dates *(yyyy-Mon-dd)*

Other Addictive Behavior(s)

Previous Treatment for Psychiatric, Addiction and/or Chronic Pain Conditions

Program Name	Attendance Date *(yyyy-Mon-dd)*	Completed
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes

Legal History

Does client have current legal involvement? ☐ No ☐ Yes ► Please specify

Is there any legal history involving Violence ☐ No ☐ Yes ► Please specify

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Client's current involvement in community agencies, mutual help, treatment, etc., relevant to this application	
Program Name	**Attendance Date** *(yyyy-Mon-dd)*

Client's Treatment Goals

Name	Signature	Date *(yyyy-Mon-dd)*