Dear Referral Agent,

Thank you for your interest in the Family Treatment Centre. At our center we:

- Require the parent to have custody of their child(ren) for two month before admission.
- If your client has children in someone else's care they must have them back in their care and be actively parenting for 2 months before they can apply.
- We provide a 6 week inpatient addiction treatment program for mothers with dependent children aged 0 – 12 years.
- We provide day care for children 5yo and under and school for children 6-12yo

To attend our center:

- All applicants must have a valid Saskatchewan Health Number.
- All clients must be detoxed for 7 Days before admission.
- Parents CAN be on methadone/suboxone.
- Clients must have housing to return to after completion of treatment.
- Travel plans to and from the Centre are the responsibility of the client and or referral agent and must be arranged before admission.

Intake Process:

1. Please complete the intake forms with your client
2. Have your client complete a medical form with their health care provider for themselves and one for each of the children attending.
3. Fax the intake forms along with medicals to 306-763-4670.
4. Our intake coordinator will review the forms and contact you if the forms are not complete or if we have further questions.
5. Once we receive a completed referral our intake coordinator will call both the referring agent and the client to conduct an intake interview to determine treatment readiness
6. If you have any questions about whether your client is a good fit for our program, please call the center @ 306-765-6375

**The following information is required prior to any client being placed on our waiting list. Please ensure all information on these forms has been completed before sending.**

## 1. CLIENT INFORMATION:

**Client's Legal Name: _____ DOB: _____ Age: _____**

**# of Children planning to attend:_____**

**Name of Child:_____ __ Ages of Child(ren) _____**

**Name of Child:_____ __ Ages of Child(ren) _____**

**Name of Child:_____ __ Ages of Child(ren) _____**

**Name of Child:_____ __ Ages of Child(ren) _____**

**Name of Child:_____ __ Ages of Child(ren) _____**

**Name of Child:_____ __ Ages of Child(ren) _____**

**Address: _____Postal Code: _____**

**Home phone #: _____ Cell phone #: _____**

**SK Health #: _____ Treaty #: _____**

**Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Common Law**

**Next of Kin to be notified in case of Emergency:**

**Name: _____ Relationship to client: _____**

**Home phone #: _____ Cell phone #: _____**

## 2. REFERRING AGENCY INFORMATION:

**Name and Title _____Agency: _____**

**Contact #: _____ Fax #:_____**

**Address: _____ Postal Code: _____**

**Referral Agent Assessment**

**Physical Health Information: (TO BE COMPLETED BY REFERRAL AGENT) this is not a medical report.**

**Physician Name: _____ Phone #: _____**

**Methadone Physician Name: _____ Phone #: _____**

**Psychiatrist Name: _____ Phone #: _____**

**Other: _____ Phone #: _____**

**Does your client have any current or previous medical concerns that will impact their ability to participate in physical activities while at the Centre? If yes, please explain:**

**_____**

**_____**

**Allergy Information (food, medical, animal, special dietary requirements): _____**

**_____**

**Is the client on the methadone maintenance program? ☐ Yes ☐ No, or Suboxone? ☐ Yes ☐ NO**

**If yes, please indicate: ·Current dose: _____ mg ·Length of time on dose: _____ Months/ Years**

**** If yes, incoming clients must arrange at least 6 weeks of methadone/ suboxone prescriptions to be brought upon arrival. ****

**Is your client currently pregnant? ☐ Yes ☐ No Expected due date: _____**

**If yes, is the client receiving prenatal care? ☐ Yes ☐ No**

**If yes, please explain: Dr or NP name: _____ Last apt date: _____**

**LEGAL INFORMATION:**

**Has client's children ever been apprehended? (If yes why?) ☐ Yes ☐No**

**_____**

**_____**

**Does your client have custody of their children now? ☐Yes ☐No**
**If yes, for how long? (If Applicable)**

**_____**

**Does your client have an open child protection/ ICFS file? ☐ Yes ☐No**
**Please explain. _____**

**_____**

**_____**

**Does your client have a condition set forth by Child & Family Services/ ICFS? ☐ Yes ☐No**
**If yes give details.**_____
_____
_____

**Is your client involved with the Criminal Justice System? ☐ Yes ☐No**

**If yes, is your client currently on probation or parole? ☐ Yes ☐No**

**Does your client have any upcoming court appearances? ☐ Yes ☐No**

**If yes, please indicate date: _____**

****Please be aware that clients will not be given permission to be absent from the program for court appearances, as we expect that all court appearances will be dealt with prior to entering treatment****

**Name of Probation/ Parole Officer: _____ Contact #: _____**

**Name of Social Services Worker: _____ Contact #: _____**

**Do you or your children have gang affiliation? ☐ Yes ☐ No**
**If yes, please explain: _____**
_____
_____

**<u>Case Management and Clinical Impressions:</u>**

**How long have you been involved with this applicant? _____**

**In your opinion, what is motivating the applicant to seek treatment? _____**

**Are you aware of any factors in the applicant's life that would prevent them from completing treatment? ( ) Yes ( ) No If yes please offer advice regarding how we can support your client to have a successful stay.**
_____
_____

**Where is the applicant's stage of change? ( ) Pre-contemplation ( ) Contemplation ( ) Preparation ( ) Action ( ) Maintenance**

**Will you continue to see the applicant once she has completed treatment ( ) Yes ( ) No**
**If yes please describe the follow up plan: _____**

**Do you require a discharge summary? ( ) Yes ( ) No**

**Please comment on your client's readiness for change and the reasons you would recommend them for inpatient specific treatment at the Family Treatment Centre. Please include client's strengths and protective factors.**

_____
_____
_____
_____
_____

_____
**Referring Agent's Signature**

**Please Have Client Complete the Following Assessment**
**If the referring agent has completed a primary assessment or LOCUS please include these documents with the referral package**

**Client's name: _____ D.O.B _____ HSN: _____**

**SUBSTANCE USE:**

Please list all substances that you have used since you began using substances.

| Type | Age of 1st Use | Date of last use | Method of Use | How often and Amount of use | Is this substance a problem? |
|---|---|---|---|---|---|
| Alcohol | | | | | |
| THC | | | | | |
| Cocaine | | | | | |
| Crystal Meth | | | | | |
| Crack | | | | | |
| Prescription Drugs | | | | | |
| Inhalant | | | | | |
| MDMA | | | | | |
| Acid | | | | | |
| Heroin | | | | | |
| Other | | | | | |
| Other | | | | | |
| Other | | | | | |

**Which of the following areas have been negatively affected by your substance use?**

( ) School Attendance ( ) Mental Health ( ) Physical Health ( ) Employment

( ) Legal ( ) Housing ( ) Financial

( ) Leisure Time ( ) Other: _____

( ) Family Relationships

**Is there a history of substance abuse in your family of origin?** ( ) Yes ( ) No

If Yes please explain _____

---

**Do you have any of the following process addictions?** ( ) Gambling ( ) Shopping ( ) Work ( ) Sex

( ) Other: _____

**Have you ever attended treatment before?** ( ) Yes ( ) No

If yes:

| Date | Name of Center | Completed | Reason |
|---|---|---|---|
| | | ( ) Yes ( ) No | If No why? |
| | | ( ) Yes ( ) No | If No why? |
| | | ( ) Yes ( ) No | If No why? |

**What supports have you utilized in your community for your substance use?**

( ) Alcoholics Anonymous ( ) Cultural supports

( ) Narcotics Anonymous ( ) Other Support Group

( ) Counselling ( ) Other: _____

**What is the longest period you have been able to stay free of substance?** _____

**What worked for you to stay free of substance?** _____

---

**We are a gender specific program and have identified that many of our women have experienced the same abuse, trauma and struggles with mental health in their past please check off those that apply to you**

( ) Domestic Violence ( ) Codependency ( ) Anxiety/Panic ( ) Anger ( ) Self Harm

( ) Childhood abuse ( ) Sexual Abuse ( ) FAS/FAE ( ) ADHD

( ) Greif and Loss ( ) Depression ( ) Suicide ideation/attempt

( ) Residential School Survivor ( ) daughter or granddaughter of residential school survivor

**MENTAL HEALTH INFORMATION:**

Do you have a history of Mental Illness? ( ) Yes ( ) No
If yes do you feel your illness is ( ) Stable ( ) Needs to be stabilized

What Mental Health conditions have you been treated for by a Mental Health professional during her life-time?

| | | |
|---|---|---|
| ☐ Depression | ☐ Sleep Disorder | ☐ Psychosis |
| ☐ Schizophrenia | ☐ Substance Related Disorder | ☐ Conduct Disorder |
| ☐ Bi-Polar | ☐ Dissociative Disorder | ☐ Eating Disorder |
| ☐ Anxiety | ☐ Personality Disorder | ☐ Impulse Control |

☐ Other: _____

**Please provide any additional information you Mental Illness**:
_____
_____

**Education Level:** ( ) Grade completed ____ ( )High School Diploma ( ) Trade School ( )Post-Secondary

**Difficulty Reading and Writing** ( ) Yes ( ) No **Learning Difficulties** ( ) Yes ( ) No

**Do you require a wheelchair accessible room**? ( ) Yes ( ) No

**Do you or your children have any physical limitations that FTC should be aware of?** ( ) Yes ( ) No
If yes please explain _____

**DANGER TO SELF OR OTHERS: (SUICIDE SCREEN)**

All clients must be screened and where appropriate assessed for suicidal thoughts and behaviors.

1. Are you having any feelings of hopelessness, helplessness or depression? ( ) Yes ( ) No
   If yes please explain: _____
   _____

2. Have you had any thoughts, urges or behaviors related to harming yourself? ( ) Yes ( ) No
   If yes please explain: _____
   _____

3. Have you recently engaged in any reckless behavior related to harming yourself or others?
   ( ) Yes ( ) No
   If yes please explain:_____
   _____

4. Have you had thoughts you would rather not be alive? ( ) Yes ( ) No
   If yes please explain: _____
   _____

5. Are you thinking of suicide? ( ) Yes ( ) No
   If yes please explain: _____
   _____

6. Have you made any current plans? ( ) Yes ( ) No
   If yes please explain: _____
   _____

7. Do you have the means to act on your plan? ( ) Yes ( ) No
   If yes please explain: _____
   _____

8. Do you currently or have you engaged in self-harm (e.g. cutting, burning) ( ) Yes ( ) No
   If yes please explain: _____
   _____

9. Have you ever been aggressive toward others? (thoughts, intimidation, violence) ( ) Yes ( ) No
   If Yes please explain: _____
   _____

**MOTIVATION:**

1. **What do you hope to gain by attending treatment? Please explain.**

2. **Can you share a family strength?**

**I understand that the Family Treatment Centre is a Full 6 week program and it is mandatory to attend and participate in all aspects of the programming.**

Any additional comments:

Client's Signature

Date

Saskatchewan Health Authority

**CHILD REGISTRATION FORM: (1 per child) Page 1 0f 2**

**Child's Full Name: _____ HSN# _____**
**Birth Date: _____ Age: _____ Gender: _____**
**Family Physician: _____ Contact #: _____**

**Medical Information**:

Child's Diagnosis: _____
Medications: _____
_____
Allergies (food, medical, animal, or otherwise): _____
_____

Immunization (have you chosen to immunize your child): ☐ Yes ☐ No
If yes, are they up to date? ☐ Yes ☐ No

**Education Information**:

School Attending: _____ Contact #: _____
Teacher's Name: _____ Grade: _____

**Psychological History**:
Has your child personally experienced or been exposed to any of the following:

| | | | |
|---|---|---|---|
| **Depression** | ☐ **Experienced** | ☐ **Exposed to** | **when** |
| **Death/ Grief/ Loss** | ☐ Experienced | ☐ Exposed to | when |
| **Anxiety Disorders** | ☐ Experienced | ☐ Exposed to | when |
| **Panic Disorders** | ☐ Experienced | ☐ Exposed to | when |
| **Phobias** | ☐ Experienced | ☐ Exposed to | when |
| **Abuse (Physical, Emotional, Mental, and Sexual)** | ☐ Experienced | ☐ Exposed to | when |
| **Relationship problems at home** | ☐ Experienced | ☐ Exposed to | when |
| **Relationship problems at school** | ☐ Experienced | ☐ Exposed to | when |
| **Drug problems** | ☐ Experienced | ☐ Exposed to | when |
| **Alcohol problems** | ☐ Experienced | ☐ Exposed to | when |
| **Violence or Anger problems** | ☐ Experienced | ☐ Exposed to | when |
| **Suicide** | ☐ Experienced | ☐ Exposed to | when |
| **Difficulty at school** | ☐ Experienced | ☐ Exposed to | when |

Physical harm to others (people or others) ☐ Yes ☐ No
Conflict with the Law ☐ Yes ☐ No

Other: _____

**Please initial any/and all additions to this form)**

Saskatchewan Health Authority

**Name:** _____

**CHILD REGISTRATION FORM (cont.)**: (1 per child) **Page 2 0f 2**

**Emotional & Physical Skills, Challenges and Interests**

Child's strong likes: _____

_____

_____

Strong dislikes: _____

_____

_____

Child's strengths: _____

_____

_____

Weaknesses or things child finds hard to do: _____

_____

_____

**Social Behavior**:

Children often show how they feel by what they do and not what they say. What does your child do when he or she is stressed or upset? _____

_____

_____

What is the best way to help your child calm down or relax? _____

_____

_____

**Circle** the word that best describes the frequency of such behaviors:

***Note- Always= More than twice a week; Often= Once a week; Sometimes= Once every 2-4 weeks; Rarely= Once every 2-4 months, or has done it in the past**

| Try to run away | Always | Often | Sometimes | Rarely | Never |
|---|---|---|---|---|---|
| Try to hurt caregiver by biting, hitting, kicking, or other harmful action | Always | Often | Sometimes | Rarely | Never |
| Try to hurt other children by biting, kicking, hitting or other harmful action | Always | Often | Sometimes | Rarely | Never |
| Withdraw | Always | Often | Sometimes | Rarely | Never |
| Tantrum | Always | Often | Sometimes | Rarely | Never |
| Refuse to cooperate | Always | Often | Sometimes | Rarely | Never |
| Becomes silly or inappropriate | Always | Often | Sometimes | Rarely | Never |
| Throw or break things | Always | Often | Sometimes | Rarely | Never |
| Attention seeking behaviors | Always | Often | Sometimes | Rarely | Never |

Saskatchewan Health Authority

**Please print clearly, Medical will be returned if unable to read**

**PHN: _____**
**DOB: _____**

**Return to Family Treatment Centre**
1200 – 24th St West
Prince Albert, SK S6V 5T4
Phone: 306-765-6375
Fax: 306-763-4670
Nurse's office: 306-765-6377

## Pre Admission Physical Examination Adult

**Date**: _____

**Please check yes or no to indicate if the client is currently being treated for or if they have a history of any of the following**

| | Yes | NO | Please provide details |
|---|---|---|---|
| TB | | | |
| Heart Disease | | | |
| Mental Illness | | | |
| Epilepsy or Seizures | | | |
| High blood pressure | | | |
| Cancer | | | |
| Allergies | | | |
| Stroke | | | |
| Diabetes | | | |
| Chronic Pain | | | |
| Sexually transmitted infections | | | |
| Lung disease | | | |
| HIV/AIDS | | | |
| Hepatitis A B C | | | |
| Lice or Scabies | | | |
| Pregnancy | | | LMP: G: P: |
| Past injuries | | | |
| Physical limitations | | | |
| Special diet | | | |
| **Current Medications**<br>_____<br>_____<br>_____ | | **Dose**<br>_____<br>_____<br>_____ | **Please ensure that your patient has sufficient refills on necessary prescriptions to encompass the six week treatment period. Prescriptions can be sent to the Medi-Center Pharmacy (PH: 306-763-2022 FAX: 306-764-0602)** | |

**Physicians Name:_____** **Physicians Signature:_____**

**By signing this for, I give authorization for any medical information to be released by the physician**

**Client Signature_____** **Date:_____**

**Note: Please attach any necessary reports or lab results that you think may be beneficial**

Saskatchewan Health Authority

Name:_____
PHN: _____
DOB: _____

**Please print clearly, Medical will be returned if unable to read**

Return **Family Treatment Center**
1200 24th St. West
Prince Albert, Sk. S6V 5T4
Phone: 306-765-6375
Fax: 306-763-4670

## Pre Admission Physical Examination – CHILD (one form per child)

**Date:_____**

**Please check yes or no to indicate if the client is currently being treated for or if they have a history of any of the following:**

| | YES | NO | Please provide details |
|---|---|---|---|
| Tuberculosis | | | |
| Asthma | | | |
| Skin conditions | | | |
| Dental issues | | | |
| Allergies | | | |
| Lice or Scabies | | | |
| Frequent ear infections | | | |
| Hospitalizations | | | |
| Congenital disorders | | | |
| Neonatal Abstinence Syndrome | | | |
| Mental Health Concerns | | | |
| Past Injuries | | | |
| Physical Limitations | | | |
| Immunizations up to date | | | |
| **Other (Please list):** | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Current Medications** | **Dose** | **Please ensure that your patient has sufficient refills on necessary prescriptions to encompass the six week treatment period. Prescriptions can be sent to the Medi-Center Pharmacy (Ph: 306-763-2022 Fax 306-764-0602)** |
|---|---|---|
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |

Physician Name: _____ Physician Signature: _____

**By signing this form, I give authorization for any medical information to be released by the physician**

**Client Signature: _____** **Date: _____**

**Note: Please attach any necessary reports or lab results that you think may be beneficial**

**Family Treatment Centre- Saskatchewan Health Authority**
**Consent Form**

Name: _____D.O.B:_____HSN:_____

I voluntarily consent to the exchange of verbal and written information concerning my condition and the services I received, for the purpose of my recovery and treatment, between PAPHR Family Treatment Centre and the following individuals and/or organizations:

| ✔ | Organization | Name & Telephone | Email | Additions/ Date/Sign | Review date & Initial |
|---|---|---|---|---|---|
| | Addiction Services Outpatients Clinic | | | | |
| | Indian Child and Family Services | | | | |
| | Social Services- Child protection | | | | |
| | Methadone Clinic | | | | |
| | Physiatrist | | | | |
| | Psychiatry | | | | |
| | Family Physician | | | | |
| | Mental health services | | | | |
| | Social Services- Financial | | | | |
| | School | | | | |
| | Place of Employment | | | | |
| | Early Childhood Intervention | | | | |
| | Children's daycare | | | | |
| | Native Co-ord. Council – NCC | | | | |
| | Pharmacy | | | | |
| | Probation Officer | | | | |
| | Parole Officer | | | | |
| | Family-specific | | | | |
| | Other: | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Client Checklist of what to bring: (Please review with client)**

- ✓ Alcohol Free personal hygiene products (shampoo, soap, toothbrush, etc)
- ✓ Feminine products (tampons, pads)
- ✓ Six weeks of prescribed medication (to be turned in at intake)
- ✓ Six weeks of methadone prescription when applicable
- ✓ Spending Money
- ✓ Cigarettes if you choose to smoke to last you 14 days
- ✓ Alarm clock
- ✓ Laundry soap for 6 weeks NOT (He)
- ✓ Diapers, pull-ups and baby wipes
- ✓ Baby formula for 6 weeks if needed
- ✓ Your **child's stroller** and favorite toys (Maximum of 3)
- ✓ Mother and child(ren) identification (Hospitalization Cards), Treaty Card
- ✓ Appropriate clothing and footwear for the weather
- ✓ Bathing suits for both mom & child. (NO cotton t-shirts are allowed in the pools).

**What will be allowed only during leave pass time on Saturday and Sunday:**

- ✓ Cell phones, MP# players, I-pods, laptops, I-pads, movies, valuables, cd's etc.
  **These items will be placed in a locker and you will not be able to use them while in the Family Treatment Centre)**

**What not to bring:**

- ✓ Provocative/ inappropriate clothing or reading materials
- ✓ Personal gaming devices
- ✓ Perfumes

**NOTE: Belongings will be searched upon arrival and Discharge and periodically throughout your stay and all unsafe products will be removed.**