Dear Referral Agent,

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

- Provide **a 6 week long inpatient addiction treatment program for mothers with dependent children aged 0 – 12 years. Children can attend treatment with their parent.**
- Children five and under attend a professionally staffed daycare and school aged children attend a school classroom supported by a teacher.
- Families stay in single family units each with their own washroom.
- We provide holistic, gender responsive, and trauma informed care.

Intake Process:

1. Please complete the intake forms with your client. Review our client handbook and "What to Bring to Treatment" (included in the referral package) 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 forms are complete you and your client will be provided with a Tentative Intake Date. A phone interview with the client will be completed 2 week prior to admission with our intake coordinator to explain the expectations and answer any questions. On completion of this phone interview a confirmed intake date will be provided.
6. Clients must have all prescriptions, including Methadone faxed to Medi-Centre Pharmacy at 306-764-0602 or to our Centre at 306-763-4670.
7. Please have school aged children bring school work that is deemed important by their teacher.
8. It is important clients arrive on their scheduled intake date and time. **If there are delays please call 306-765-6375.**

To attend our center:

- We are a provincial resource – we accept referrals from both on and off reserves and all applicants must have a valid Saskatchewan Health Number.
- **The parent MUST have custody of the child(ren) for two month prior to admission**.
- 7 Day Detox must be completed before intake.
- Parents can be accessing methadone/ suboxone treatment.
- **All court proceedings must be dealt with prior to admission** as clients cannot leave for court appearances, and we ask that no other appointments be booked for the parent or children during the 6 week stay.
- Clients must have a residence 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 prior to admission. **Should a participant discharge earlier than planned, transportation must be arranged within 24 hours.**

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 _____ _____ _____		**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)**	

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.