NNADAP/YSAC Family Intake & Referral Application

Child / Dependent

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS. Form to be completed by referring agent.

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

Date of Application: (MM/DD/YYYY) _____

Date Application Received by Treatment Centre: (MM/DD/YYYY) _____

Name of the referral worker/agency: _____

Phone number: _____

A. Client Information

Surname:

First Name:

Nickname/other name known by:

Date of Birth:

Age:

Sex:

Health Card Number:

Health Card Expiry Date:

Client Address:

Client Phone:

Language Spoken:

Language Preferred:

Language Understood:

Status Indian:

Treaty Number:

Band Name:

Other Indigenous Status:

Relationship Status:

Emergency Contact:

Next of Kin:

Relationship to Next of Kin:

Phone number of Next of Kin:

Custody Information:

- ☐ Customary / Traditional
- ☐ Adoption
- ☐ Biological
- ☐ Kinship / Foster
- ☐ Recent Apprehension
- ☐ Voluntary Family Services
- ☐ Orders of Supervision
- ☐ Unsupervised Visitation
- ☐ Continued Supervision
- ☐ Temporary Supervision
- ☐ Voluntary Placement Agreement
- ☐ Continuous Care (Ongoing Family Services)

Social Worker Name/Contact Information:

_____

_____

B. Education and Social Status

Grade Level	*Has an Individual Education Plan*	*Has an Academic Assessment*	*Has Received Guidance Counselling*	*Has been previously apprehended*	*Has received a Behavior Assessment*
	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

C. Legal Status

Has your client ever been in trouble with the law? ☐ Yes ☐ No

If yes, please explain:_____

Is your client under any of these legal involvements?

☐ Criminal Court ☐ Family Court ☐ Drug Court Treatment ☐ Probation

☐ Charges Pending ☐ Court Referral ☐ Court Order ☐ Unknown

☐ Restorative Justice ☐ No Involvement

Gang Involvement: ☐ Yes ☐ No

Is your client involved in any of the following legal conditions?

☐ Bail ☐ Parole ☐ Temporary Absence ☐ No Involvement

If other, please specify:_____

Was alcohol or any other substances; such as 'sniff' or other drugs involved in your client's legal dealing?

☐ Yes ☐ No ☐ Unknown ☐ Other

If other, please specify:_____

Is your client seeking treatment as a result of a court order or family service order?

☐ Yes ☐ No ☐ Unknown

If yes, please explain:_____

D. Chemical Use History - *Substance misuse prior to treatment history:*

At what age did your client start sniffing? _____

At what age did your client start drinking? _____

At what age did your client start using other drugs? _____

Has anyone in their family or community received treatment for solvent/substance abuse?

☐ Yes ☐ No ☐ Unknown

If yes, please explain:_____

Has the client participated in a non-residential/community-based substance abuse program?

☐ Yes ☐ No ☐ Unknown

If yes, please explain:_____

Has your client received prior treatment at a residential addiction centre?

☐ Yes ☐ No ☐ Unknown

If yes, please explain:_____

Treatment Location	*Treatment Date*	*Describe*

Substance misuse for last year: _____

Has your client used substances for the last year? _____
If yes, complete a DUSI-R Assessment

E. Withdrawal Symptoms

Has your client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptoms	*Describe*
Blackouts ☐ Yes ☐ No ☐ Unknown	
Hallucinations ☐ Yes ☐ No ☐ Unknown	
Nausea/Vomiting ☐ Yes ☐ No ☐ Unknown	
Seizures ☐ Yes ☐ No ☐ Unknown	
Shakes ☐ Yes ☐ No ☐ Unknown	
Delirium Tremens (DTs) ☐ Yes ☐ No ☐ Unknown	
Ever experienced DTs? ☐ Yes ☐ No ☐ Unknown	

F. Mental Health History

Provide the following information about the client's mental health status:

Mental Illness	*Describe*
Been diagnosed with a mental illness ☐ Yes ☐ No ☐ Unknown	
Currently being treated ☐ Yes ☐ No ☐ Unknown	
Currently on psychiatric medication ☐ Yes ☐ No ☐ Unknown	
Taking medication consistently ☐ Yes ☐ No ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.) ☐ Yes ☐ No ☐ Unknown	
Sex (promiscuity, etc.) ☐ Yes ☐ No ☐ Unknown	
Internet / texting ☐ Yes ☐ No ☐ Unknown	
Gaming (video games and APP games) ☐ Yes ☐ No ☐ Unknown	
Has your client ever spoken or written about killing themself? ☐ Yes ☐ No ☐ Unknown	
Previous suicide attempts/ideations? If yes, please explain how and when: ☐ Yes ☐ No ☐ Unknown	
Hospitalized for suicide attempts? If yes, when? ☐ Yes ☐ No ☐ Unknown	

Currently suicidal? ☐ Yes ☐ No ☐ Unknown	
Has your client received prior treatment from mental health services? If yes, indicate below: ☐ Yes ☐ No ☐ Unknown	
Treatment Location: ***Treatment Date:***	
If any treatment program was NOT completed, please provide details:	

G. Social Functioning

Is there any known history of sexual abuse? ☐ Yes ☐ No ☐ Unknown

Is there any known history of physical abuse? ☐ Yes ☐ No ☐ Unknown

Is there any history of family violence that the client may have been witness to?

☐ Yes ☐ No ☐ Unknown

Any self-harming behaviour(s)? ☐ Yes ☐ No ☐ Unknown

Please indicate which (if any) of the following issues have been a part of your client's family life and provide pertinent details in the associated space.

- ☐ Physically aggressive, abusive, or threatening behaviors
- ☐ Sexually aggressive behaviors or promiscuity (verbal or physical)
- ☐ Verbally aggressive abusive, or threatening behaviors
- ☐ Uncontrollable outbursts of anger
- ☐ Depression
- ☐ Suicidal ideation
- ☐ Suicidal attempts
- ☐ Self-harm or mutilation

Please specify details and dates:

- ☐ Running away
- ☐ Recklessness/unhealthy risk taking
- ☐ Severe and debilitating anxiety
- ☐ Co-dependent/controlling
- ☐ Eating disorder
- ☐ ADHD (Attention Deficit Hyperactivity Disorder)

Please specify details and dates:

- ☐ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects)
- ☐ Mental Disorder
- ☐ Intellectual Development Disability
- ☐ Difficulty following rules or regulations
- ☐ Dislike of or disregard for the authority figures
- ☐ Substance withdrawal (detoxification)
- ☐ Medical complications that may affect treatment
- ☐ Other destructive behaviors (ie. vandalism, arson)

Does your client go to school?
☐ Yes ☐ No

Child Welfare Involvement?
☐ Yes ☐ No ☐ Unknown

H. Historical Trauma Event

Has your client experienced historical trauma? ☐ Yes ☐ No ☐ Unknown

What kind of historical trauma did your client experience?

☐ Attended residential school

☐ Experienced trauma in residential school

☐ Experienced physical abuse (not residential school)

☐ Experienced emotional abuse (not residential school)

☐ Experienced sexual abuse (not residential school)

☐ Experienced trauma in foster care

☐ Experienced multiple foster care placements

☐ Was separated from parents/family for other reasons

☐ A family member/friend attempted suicide in the past year

☐ Experienced natural death oof a family/friend in the past year

☐ Experienced death of a family member/friend in the past year

☐ Experienced multiple deaths in my community in the past year

☐ Experienced disaster/crisis in my community in the past year

☐ Parent(s) attended residential school

☐ Grandparent(s) attended residential school

☐ Child abuse

☐ Intergenerational trauma

☐ Relocation

☐ PTSD

☐ Sixties Scoop Survivor

☐ Foster Placement

☐ Other, please specify: _____

PRE-ADMISSION MEDICAL ASSESSMENT FORM

Legal Client Name:_____ Preferred Name:_____
Prov. Health Card #:_____ Status/Beneficiary #: _____
Date of Birth: _____
Home Address:
_____
_____ Postal Code: _____
Home Phone #: _____

To the Physician:
The above named client is to be medically assessed as a requirement for the participation in a residential treatment program at Charles J Andrew Youth Treatment Centre, Sheshatshiu, NL for Alcohol/Drug/Inhalant Abuse/ Dependency.
Charles J Andrew requires each client to have a complete physical examination prior to admission.

1. Please provide any pertinent medical history that should be available to a health care provider should the client need health care while at treatment.
   _____
   _____
   _____

2. Is the client on any medication? Yes/no
   If yes, please list the name of the medication, the dose etc._____
   _____
   _____

3. Does the client have any allergies? Yes/no
   Comments:
   _____
   _____

4. Does the client have any dietary restrictions? Yes/no
   If yes, do they require medication for this?
   _____
   _____

5. Does the client currently have a communicable disease that would be a risk to others? Yes/no

6. Has the client been checked and cleared for lice and scabies? Yes/no
   If yes have they been treated? _____

   Has the client been checked and cleared for MRSA? Yes/no
   If yes have they been treated? _____

7. Tuberculosis:
   a) Does the client have any signs or symptoms consistent with active Tuberculosis? Yes/no
      If yes ensure that the client is investigated for TB and is not infectious before entering the treatment centre.
   b) Date and result of the most recent Tuberculin skin test (TST): _____
   c) Date and result of the most recent chest x-ray if TST is positive: _____

8. Is the client pregnant? Yes/no
9. Are you aware of any additional medical conditions or limitations that may influence the clients' participation in the program? Yes/no
   If yes, please explain:
   _____
   _____

10. Please provide an up to date copy of the clients immunization record

I hereby certify that I have examined the above named as required and the said person is physically and mentally fit to undertake the treatment program offered by Charles J Andrew Youth Treatment Centre.

Physician's Name: _____
Please Print

Address:

_____

_____ Postal code _____

Telephone: _____ Fax: _____

Physician's signature: _____