NNADAP/YSAC Family Intake & Referral Application

Spouse / Partner

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:

Income Source:

- ☐ Assistance (Social Assistance or Government)
- ☐ Disability
- ☐ Employment Income/Occupation
- ☐ Employment Insurance (EI)
- ☐ None
- ☐ Other

Employment Status:

☐ Self-Employed	☐ Full time Employment	☐ Part Time Employment
☐ Full Time Seasonal	☐ Part Time Seasonal	☐ Full Time Student
☐ Part Time Student	☐ Unemployed	☐ Social Assistance
☐ Disability Assistance	☐ Worker's Compensation	☐ Volunteer
☐ Retired	☐ Student	☐ Training
☐ Homemaker	☐ Other	

B. 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:_____

C. 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? _____

Does anyone else in their family use solvents/substances? _____
If yes, please specify: _____

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

D. Pre-Treatment

Has the client attended a pre-treatment counselling session with you?

☐ Yes ☐ No ☐ Unknown

If yes, please explain:_____

Has the client attended any withdrawal management prior to coming to the treatment centre?

☐ Yes ☐ No ☐ Unknown

If yes, please explain:_____

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

Please specify details and dates:

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

Please specify details and dates:

- ☐ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects)
- ☐ Intellectual Development Disability
- ☐ Dislike of or disregard for the authority figures
- ☐ Medical complications that may affect treatment
- ☐ Mental Disorder
- ☐ Difficulty following rules or regulations
- ☐ Substance withdrawal (detoxification)
- ☐ 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 has your client experienced?

☐ Attended residential school

☐ Experienced trauma in residential school

☐ Experiences 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: _____

Charles J. Andrew Youth and Family Treatment Centre

Motivational Interviewing Questionnaire

1. Did anything happen that made you feel that you have to go to treatment? If yes, what happened?

2. Do you see yourself completing the full program?

3. Have you made arrangements to complete the full program with work, school, etc?

4. Are there any medical issues that may interfere with your treatment program?

5. Do you have any upcoming court dates?

6. What are your goals in life? Do you want to work full time? Do you want to have a happy relationship with your spouse/children/family?

7. What would you like to work on during your treatment program?

8. Do you have others that can help you or listen to you?

CHARLES J. ANDREW YOUTH and FAMILY TREATMENT CENTRE
PO Box 109
Sheshatshiu, Labrador A0P 1M0
Telephone: 709-497-8995 **Fax: 709-497-8993**

CONSENT TO MEDICAL TREATMENT

I, _____, hereby give permission for myself and my child(ren)_____,_____,_____

To allow a physician selected by Charles J. Andrew Youth and Family Treatment Centre to hospitalize and/or procure medical treatment for myself, and my child(ren), as listed above, in case of a serious accident or medical emergency and I am unable to make the necessary decision(s).

Band/Beneficiary Number: _____

Health Care Numbers & Province: _____

Signature of Client: _____ Date: _____

Signature of CJAY staff: _____ Date: _____

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EDUCATION CONSENT

I, _____, do hereby give consent to the Charles J. Andrew Youth and Family Treatment Centre.
Parent/Guardian

And Family Treatment Centre to provide minimum educational programming for

_____ _____
Youth/Child(ren) Date of Birth(s)

I also give permission to release my child's school student records to be quickly returned to home/school upon completion of treatment.

_____ _____
Parent/Guardian Signature Youth Signature

_____ _____
Parent/Guardian Name Youth Name

_____ _____
Date Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

1. I hereby authorize the Charles J. Andrew Youth and Family Treatment Centre to receive from and/or release information to any person or agency (such as physician, hospital, vocational and other agencies) with due safeguard or confidentiality, on my behalf.

   Date: _____

   Signed: _____

   Witness: _____

2. I do not wish any information, abstracts or any indication of any manner about myself or my stay here to be released to any person or agency, unless I give specific written notice to the Charles J. Andrew Youth and Family Treatment Centre to indicate authorization for release.

   Date: _____

   Signed: _____

   Witness: _____

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LIABILITY WAIVER

I _____ give permission for myself and my child(ren),
_____, _____, _____

to take part in various community, sporting, cultural and educational activities while attending the healing program at Charles J. Andrew Youth and Family Treatment Centre.

I understand that although my child will be under adult supervision during all activities, accidents and injuries are still possible and sometimes inevitable.

I hereby absolve the Treatment Centre and its staff from any liability should an accidental injury occur to myself and my child(ren) during their stay at CJAY; including possible accident/injury during vehicle transportation to and from program outings.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

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RELEASE AND WAIVER FOR NUTSHIMIT PROGRAM PARTICIPANTS

Adults Full Name: _____ Date: _____/_____/_____
Date of birth___/___/___, Date of birth ___/___/___, Date of birth ___/___/_____
Child(ren) full name: _____ Date of birth ___/___/_____
Address: _____

I UNDERSTAND that the Nutshimit Program is to provide myself and my child(ren) with the opportunity to participate in a healing process; and to provide myself with instruction in a traditional cultural lifestyle (such as hunting, fishing, gathering, and trapping) while away from the distractions and difficulties of life in the community, with the hope that any previous difficulties will be overcome.

MY DECISION TO PARTICIPATE in the Nutshimit Program while at the Charles J Andrew Youth and Family Treatment Centre is of my own choosing and that of my family. I am mindful of the importance of safety and I am aware of all aspects of safety, including and during outdoor and indoor programming. I have had the opportunity to review the policies and procedures of the Nutshimit Program provided by CJAY.

I ALSO UNDERSTAND that the program will involve the use and teaching of traditional lifestyles and skills (including counseling, preparation of food, gathering, trapping, and hunting) and that I may use and/or have access to, and or operate, equipment such as boats, snowmobiles, chainsaws, knives, harpoons, and firearms, and/or other equipment and/or be in the vicinity where firearms and/or other equipment are being used, discharged and stored. I SHALL, at all times during my participation in the program, use and take such measures to ensure the safety of myself, my family and the other participants and staff of the Charles J. Andrew Youth and Family Treatment Centre.

IN CONSIDERATON of the CHARLES J ANDREW YOUTH and FAMILY TREATMENT CENTRE accepting me to be a participant of the Nutshimit Program, I _____, my heirs, and executers, RELEASE the CHARLES J ANDREW YOUTH and FAMILY TREATMENT CENTRE and its respective servants, agents, or employees from any and all claims, demands, actions or causes of actions arising out of or in consequences of any loss, injury or damage to my person or property or to any family members or relations that may be attending the said program with me incurred while attending or participating in the Nutshimit Program, notwithstanding any such loss, injury or damage may have arisen by reason of the negligence of the CHARLES J ANDREW YOUTH and FAMILY TREATMENT CENTRE, its respective servants, gents, or employees.

_____	_____	_____
Participants Signature	Clients Signature	Witness

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PHOTOGRAPH RELEASE

From time-to-time CJAY will use un-identifying client photos in annual reports, conference summaries, reports, brochures, advertisements, newsletters, website and power point presentations. CJAY strives to uphold the strictest confidentiality about its clients and their families; therefore, we do not use full face photos of clients and strive to only use photos which do not identify the client.

****

PERMISSION GIVEN

I _____ hereby give permission for CJAY to use photographs of
Client's Name

_____ (which will not show my own or my child's face or identifies
Client/Youth Name
them in anyway) in promotional material, on its website, in its newsletter, annual reports, conference summaries, reports, and power point presentations.

****

PERMISSION DENIED

I _____ do not give permission for CJAY to use any photographs of
Client's Name

_____ (which will not show my child's face or identifies them in any way)
Client/Youth Name
in promotional material, on its website, in its newsletter, annual reports, conference summaries, reports, and power point presentations.

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Data Base (AMIS) Consent Form

I _____ give consent for my information and my family members
(name of client)
information to be entered into the CJAY data base (AMIS). I also consent that this information be

shared with other treatment centres and treatment centre staff when applicable or necessary.

_____
(name of family member)

_____
(name of family member)

_____
(name of family member)

_____
(name of family member)

_____
(name of family member)

_____
(name of family member)

_____ _____
(Clients Signature) (Date)

_____ _____
(Witness Signature) (Date)

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COMMITMENT TO CARE

Preamble:

Charles J. Andrew Youth & Family Treatment Centre is a ten (10) bed facility, seeking to provide cultural and therapeutic treatment to youth and families who are expressing a need to change. It is important to remember that life events that brought the family to the point of needing residential treatment are varied and it is therefore appropriate to understand that the treatment length of eight (8) weeks is necessary for a successful treatment process.

Charles J. Andrew Youth and Family Treatment Centre recognizes and encourages you, the family members and the referring/support worker to work together on a treatment plan.

This form is a statement of what you are willing to do:

Family:

1. What are your goals for attending treatment?

_____

_____

_____

_____

2. Are you willing to revisit these goals at the halfway point?
_____yes _____no

Worker:

1. Will you call to check on the progress of your client? _____yes _____no
2. Are you planning on visiting our client during treatment? _____yes _____no
3. Are you willing to revisit these goals at the halfway point? _____yes _____no

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COMMITMENT TO CARE

Is there anyone WE SHOULD NOT CONTACT while the youth and family are in treatment?

_____yes _____no

If so, what are the names?

_____

_____

_____

_____

We commit to the plans stated on page 1 of the Commitment to Care form:

- **As the family members, we are committing to the full eight (8) weeks of treatment.**

  Signature: _____ **Date:** _____

  Signature: _____ **Date:** _____

- **As the referring/support Worker, I am committing to the full eight (8) weeks of treatment.**

  Signature: _____ **Date:** _____

- **As CJAY staff, we are committing to the full eight (8) weeks of treatment:**

  Signature: _____ **Date:** _____

  Signature: _____ **Date:** _____

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COMMITMENT TO CARE

List who will be involved in the clients after care plan, of which outreach will be in contact with to develop a plan. The plan will be monitored once the client leaves treatment and up to two years.

Professional and/or family role:	**Name:** **Address:** **Email:** **Phone number:**
Professional and/or family role:	**Name:** **Address:** **Email:** **Phone number:**
Professional and/or family role:	**Name:** **Address:** **Email:** **Phone number:**
Professional and/or family role:	**Name:** **Address:** **Email:** **Phone number:**

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. <u>Please provide an up to date copy of the clients immunization record</u>

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: _____