



Gwekwaadziwin Miikan

2027 Hwy 540, Little Current ON, POP 1K0 Phone (705) 370-5307 Fax (705) 370-5308

Referral Package for Gwekwaadziwin Miikan

Gwekwaadziwin Miikan provides a client centred model of mental health and addictions treatment for youth aged 19-30. Gwekwaadziwin focuses on wellness, education and economic prosperity for our participants and their communities. We offer a 3-month Land Based treatment phase, 6-12 month Live in Aftercare phase and up to 6 months of Community Aftercare.

This package includes our application, consent forms and our participant consent/referral form. Please use this form for: your referral agency, emergency contact, lawyer, probation officer etc. Please make sure to initial areas of disclosure as this form is permission for us to contact to aid in your application.

Referrals can be faxed in by self, community members with applicant's consent, clinician, physician or any other professional.

Requirements for referral packages to be accepted are as follows:

- Application completed in full and signed by applicant
- Consent form reviewed and signed
- Our release form signed for permission to contact/referral
- Any legal conditions pertaining to the applicant
- A GAIN Q3 Assessment completed within the last 3-6 months. We can assist on locations to get this assessment done

Please Fax completed referrals to (705) 370-5308 - Attn Admissions

Upon receiving the intake package our Admissions Coordinator will contact to discuss the application and program. After that phone interview the required documents are:

- Our medical form completed by physician with any comments, concerns or requests highlighted from our clinical team.

When participants are approved they will be put on a wait list until we have a date available for intake. When that day is determined we will confirm with the applicant. During this time we encourage that the applicant seeks pre-treatment/counselling. We ask that the accepted applicant check in with us once a week to show commitment and to confirm pre-treatment attendance. **All participants must be detoxed and free from withdrawal symptoms at least 7 days prior to the intake date.**

We would like to thank all that are interested in our program. Please any questions call (705)370-5307.

Miigwech,

Gwekwaadziwin Miikan



Gwekwaadziwin Miikan

Youth Mental Health
& Addiction Program

Application

Ages 19-30

Phone 705-370-5307

Fax 705-370-5308

tanyat@gwek.ca

We ask for personal information to help us understand your situation so that we can determine whether Gwekwaadziwin is right for you.

Information you provide on this form is confidential.

Please Print

CLIENT INFORMATION			
Last name:		First:	Middle: Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Partnered/Common Law <input type="checkbox"/>
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Birth date: M / D / Y Age:
Please tell us any other name you like to be called:		I identify my gender as:	
Address:			P.O. Box:
City:		Province:	Postal Code:
Home Phone Number: ()		Cell Phone Number: ()	
Can we leave a message here? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we leave a message here? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:			
Provincial Medical Number:		Province of Medical Registration:	
10 Digit Status Number:		Band:	
Languages spoken:	Language preferred:	Languages understood:	
Is the applicant completing this form? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, who is completing this form?	
Do you want us to keep in touch with the person who helps you with this application?			<input type="checkbox"/> Yes <input type="checkbox"/> No
CONTACT INFORMATION			
IN CASE OF EMERGENCY			
Name of local friend or relative:		Relationship to you:	Home phone: () Work phone no.: ()
FAMILY/SUPPORTS THAT YOU CONSIDER FAMILY			
Name:	Relationship to you:		Phone no.: ()
Name:	Relationship to you:		Phone no.: ()
Name:	Relationship to you:		Phone no.: ()
AGENCY CONTACTS			
Agency:	Your contact's name:		Phone no.: ()
Agency:	Your contact's name:		Phone no.: ()
Agency:	Your contact's name:		Phone no.: ()

PROFESSIONAL CARE PROVIDERS

Doctor or Nurse Practitioner:	Address:	Phone no.: ()
Psychiatrist:	Address:	Phone no.: ()
Dentist:	Address:	Phone no.: ()

SOCIAL HISTORY

What is going on in your life that made you choose to apply for treatment at Gwekwaadziwin?

Describe your housing situation:

Who do you live with now?

Do you have a safe place to return to after treatment? Yes No

Do you have children? Yes No

How many? _____

Ages _____

If you have children, who do they live with?

Who will look after your family and your finances while you are in treatment?

Who are the main supports in your life?

Do they support this application for treatment? Yes No

Are you enrolled in school? Yes No Full time Part time/casual

Name of your school:

Program or courses you are taking:

What is the highest grade you completed in school?

Are you currently employed? Yes No Full time Part time/casual

Who is your employer?

What type of work do you do?

Have you ever been involved with a gang?

Yes No

If Yes, are you still involved? Yes No

Have you ever been the victim of abuse? Yes No

If Yes, was it reported? Yes No

What agencies are you involved with in your community?

SPIRITUAL AND PERSONAL DEVELOPMENT

Do you have relationships with any Elders? Yes No

Please tell us about this experience.

Do you practice any traditional teachings? Yes No

Please tell us about your practices.

Do you have other religious, ceremonial or spiritual beliefs or practices? Yes No

Please tell us about that.

In what ways would you like to learn or develop your spiritual beliefs?

When you think of your emotions and how they affect you, are there some emotions you would like to understand better or manage better? In what ways?

Describe any parts of your day-to-day relationships with others that you would like to handle better.

What physical activities do you enjoy?

In what ways do you want to improve your fitness or learn new physical activities?

How would you describe your strengths and talents?

What other skills you want to learn, or talents would you like to develop?

What interests you most in school or at work?

Is this something you want to learn more about? Yes No

Would you like to enroll in any kind of school program? What type?

What are the things you want to get out of treatment?

Use this space to write anything else you'd like to share with us

MEDICAL HISTORY

EYES

Sensitive to light
 Low vision
 Blurry vision or problems focusing

Double vision
 Ghost images or trailing images
 Other:

EARS

Reduced hearing
 Ringing ears

Other:

MOUTH, NOSE & THROAT

Gum disease or bleeding gums
 Tooth grinding
 Sores inside mouth, nose or throat

Pain in mouth, nose or throat
 Stuffy nose
 Other:

SKIN

Infection or abscess
 Scabies
 Lice
 Rashes, scabs

Bruises
 Ulcers or sores
 Other:

ABDOMEN

Stomach upset, ulcer, or digestive problems
 Other _____

RESPIRATORY

Asthma or any respiratory problems
 Cough
 Wheezing

Pneumonia
 Other:

CARDIOVASCULAR

Anemia
 Bruise easily, lots of bleeding from cuts
 Blood clot anywhere
 High blood pressure
 Heart rate problems (racing or pounding heart)

Heart pain, especially with exercise (angina)
 Congestive heart failure (CHF)
 Heart defect or disease
 Stroke
 Other:

GENITOURINARY

Urinary tract infection (UTI)

Other:

MUSCULOSKELETAL

Bone or joint problems

Other:

BRAIN & NERVOUS SYSTEM	
<input type="checkbox"/> Brain injury <input type="checkbox"/> Confusion <input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Hearing, seeing or feeling things that other people do not <input type="checkbox"/> Feelings of panic
ACCIDENTS	
<input type="checkbox"/> Car accident <input type="checkbox"/> Bike accident <input type="checkbox"/> Falls	<input type="checkbox"/> Head injury <input type="checkbox"/> Other accident:
INFECTION	
<input type="checkbox"/> Chest <input type="checkbox"/> Throat	<input type="checkbox"/> Skin <input type="checkbox"/> Sinus <input type="checkbox"/> Other:
OTHER DISEASES AND CONDITIONS	
<input type="checkbox"/> Diabetes Type: <input type="checkbox"/> Cancer:	<input type="checkbox"/> Liver problem: <input type="checkbox"/> Kidney problem: <input type="checkbox"/> Other:
<input type="checkbox"/> Flashbacks <input type="checkbox"/> Headaches	<input type="checkbox"/> Fainting <input type="checkbox"/> Other:
COMMUNICABLE DISEASES	
<input type="checkbox"/> Cold or flu <input type="checkbox"/> Chicken pox <input type="checkbox"/> Hepatitis A B C (circle) <input type="checkbox"/> Strep throat	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other:
WEIGHT CHANGE	
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain
How much _____ in _____ months	
SURGERY	
<input type="checkbox"/> Any surgery (please include dates if possible):	
Do you have any sexually transmitted infections?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you or could you be pregnant?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever experienced or been diagnosed with depression? Yes No

Do you have any problems related to eating? Yes No

Have you ever thought about suicide? Yes No

Have you ever tried to commit suicide? Yes No

Do you have problems with anger? Yes No

Have you ever been diagnosed with ADD or ADHD? Yes No

Do you have any learning disabilities? Yes No

Are you worried about any other emotional or mental health problems? Yes No

Have you ever received treatment for emotional or mental health issues in the community? Yes No
What type of issues were being addressed?

Where did you get the treatment?

Have you ever been hospitalized for any reason? Yes No
Why were you hospitalized?

Where?

Use this space to write anything else you'd like to share with us

SUBSTANCE USE HISTORY

Have you ever taken part in community treatment for substance or alcohol use? Yes No
 What kind of treatment?

Where and when?

Have you ever been hospitalized for substance or alcohol use? Yes No
 What kind of treatment?

Where and when?

Substance used			Used within the past:			
			Month	6 months	Up to one year	Longer than one year
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Glue/inhalants	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Methamphetamines (ecstasy, MDMA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Fentanyl	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Opiates (e.g. oxy, percs, hydro, codeine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Benzodiazepines (e.g. benzos, goofballs, roofies, Valium, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Barbiturates (e.g. barbs, downers, sleepers, reds, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Medicines (e.g. pain reliever, antihistamine, cough syrup)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				
Other Please name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smoked <input type="checkbox"/> Injected <input type="checkbox"/> Snorted <input type="checkbox"/> Swallowed				

Which drug(s) do you use most?

LEGAL HISTORY

Do you have a criminal record? Yes No
If yes, please provide more information.

Do you have any charges pending? Yes No
If Yes, what are the charges?

Do you have upcoming court dates? Yes No
If Yes, indicate when:

Have you ever been charged with sexual assault or any sexual offense? Yes No

Have you ever been charged with crimes against children? Yes No

Have you ever been charged with arson? Yes No

Have you ever been charged with assault? Yes No

Are you on parole? Yes No
Name your parole officer:

Are you on probation? Yes No
Name your probation officer:

Lawyer name:

Use this space to write anything else you'd like to share with us

The information contained in this application is true to the best of my knowledge.

Applicant signature

Date

If there is anything else you would like to share with us, feel free to attach a separate piece of paper.



Gwekwaadziwin Miikan
2027 Highway 540, Little Current, Ontario
Tel. 705-370-5307 | Fax. 705-370-5308

**Participant Consent Form
Admission and Collection of
Information**

Consent for Admission and Collection of Personal Information

I, _____ (Full Name of Participant),

born on _____ (Date of Birth),

hereby willingly agree to admittance into the Gwekwaadziwin Miikan Treatment Program and to the collection of personal information as required for admission, treatment, research and outcome measures.

I understand that the program is completely voluntary, and I may choose to leave the program at any time.

I understand the archival and use of personal information is protected by confidentiality and (PHIPA) Personal Health Information Protection Act. Personal information will not be shared without written consent unless ordered by a court of law; or if I present as a danger to myself or others, or if a concern is considered pertaining to my treatment in an emergency situation.

In the event of a medical emergency, that cannot be mitigated by the Gwekwaadziwin Miikan staff we will ensure the care is received at the nearest Emergency Centre and the emergency contact will be notified as soon as possible.

Participant Signature: _____

Date: _____

Witness Signature: _____

Date: _____



Gwekwaadziwin Miikan
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**Participant Consent Form
 Referrals**

Consent for Referral

I, _____ (Full Name of Participant),
 born on _____ (Date of Birth),
 hereby authorize the Gwekwaadziwin Miikan Treatment Program to **RELEASE/REQUEST** the
 following information to/from the person/agency listed. In order for this release to be valid,
 one column must be checked and initialed by the participant for each area of disclosure.

Person / Agency: _____ **Yes** **No** **Initials:** _____

Contact Information: Tel. (____) _____
 Fax. (____) _____

Area of Disclosure:	Yes	No	Initials
1. Assessment and Treatment Planning Information	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Discharge Summary	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Reports	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Confirmation of Attendance/Completion	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Legal Status (i.e. court cases, parole, probation)	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. All information re: Methadone/Suboxone	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Traditional Program/Resource	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Other: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

I understand that no other information will be released to any other person without my written consent unless these persons have a court order or subpoena, or I present as a danger to myself or others; or considered a concern with my treatment in an emergency situation. This consent is valid for the duration of the participants current admission to the program. Participants can opt out of this consent in writing anytime.

Participant Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____