Gwekwaadziwin Miikan

2027 Hwy 540, Little Current ON, P0P 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.

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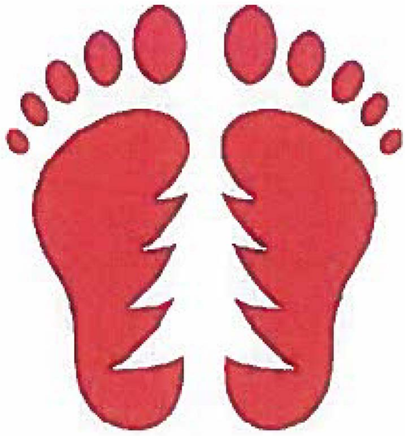
Gwekwaadziwin Miikan



# Gwekwaadziwin Miikan

## Youth Mental Health & Addiction Program

**Application**

**Ages 19-30**

**Phone 705-370-5307**

**Fax 705-370-5308**

**info@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 ❑ Married ❑ Widow/Widower ❑ Divorced/Separated ❑ Partnered/Common Law❑ |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ 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: ( ) Can we leave a message here? ❑ Yes ❑ No | Cell Phone Number: ( ) Can we leave a message here? ❑ Yes ❑ 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? ❑ Yes ❑ 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? ❑ Yes ❑ 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<br>If Yes, are you still involved? ❑ Yes ❑ No | Have you ever been the victim of abuse? ❑ Yes ❑ No<br>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 | _____ Double vision |
| _____ Low vision | _____ Ghost images or trailing images |
| _____ Blurry vision or problems focusing | _____ Other: |

### EARS

| | |
|---|---|
| _____ Reduced hearing | _____ Other: |
| _____ Ringing ears | |

### MOUTH, NOSE & THROAT

| | |
|---|---|
| _____ Gum disease or bleeding gums | _____ Pain in mouth, nose or throat |
| _____ Tooth grinding | _____ Stuffy nose |
| _____ Sores inside mouth, nose or throat | _____ Other: |

### SKIN

| | |
|---|---|
| _____ Infection or abscess | _____ Bruises |
| _____ Scabies | _____ Ulcers or sores |
| _____ Lice | _____ Other: |
| _____ Rashes, scabs | |

### ABDOMEN

_____ Stomach upset, ulcer, or digestive problems

_____ Other ______________________________

### RESPIRATORY

| | |
|---|---|
| _____ Asthma or any respiratory problems | _____ Pneumonia |
| _____ Cough | _____ Other: |
| _____ Wheezing | |

### CARDIOVASCULAR

| | |
|---|---|
| _____ Anemia | _____ Heart pain, especially with exercise (angina) |
| _____ Bruise easily, lots of bleeding from cuts | _____ Congestive heart failure (CHF) |
| _____ Blood clot anywhere | _____ Heart defect or disease |
| _____ High blood pressure | _____ Stroke |
| _____ Heart rate problems (racing or pounding heart) | _____ Other: |

### GENITOURINARY

| | |
|---|---|
| _____ Urinary tract infection (UTI) | _____ Other: |

### MUSCULOSKELETAL

| | |
|---|---|
| _____ Bone or joint problems | _____ Other: |

## BRAIN & NERVOUS SYSTEM

| | |
|---|---|
| _____ Brain injury<br>_____ Confusion<br>_____ Forgetfulnes | _____ Seizures or convulsions<br>_____ Hearing, seeing or feeling things that other people do not<br>_____ Feelings of panic |

## ACCIDENTS

| | |
|---|---|
| _____ Car accident<br>_____ Bike accident<br>_____ Falls | _____ Head injury<br>_____ Other accident: |

## INFECTION

| | |
|---|---|
| _____ Chest<br>_____ Throat | _____ Skin<br>_____ Sinus<br>_____ Other: |

## OTHER DISEASES AND CONDITIONS

| | |
|---|---|
| _____ Diabetes<br>Type:<br>_____ Cancer: | _____ Liver problem:<br>_____ Kidney problem:<br>_____ Other: |
| _____ Flashbacks<br>_____ Headaches | _____ Fainting<br>_____ Other: |

## COMMUNICABLE DISEASES

| | |
|---|---|
| _____ Cold or flu<br>_____ Chicken pox<br>_____ Hepatitis A B C (circle)<br>_____ Strep throat | _____ Tuberculosis<br>_____ Rheumatic fever<br>_____ HIV/AIDS<br>_____ Other: |

## WEIGHT CHANGE

| | |
|---|---|
| _____ Weight loss | _____ Weight gain |

How much____________in__________ months

## SURGERY

_____ Any surgery (please include dates if possible):

| | | |
|---|---|---|
| Do you have any sexually transmitted infections? | ❑ Yes | ❑ No |
| Are you or could you be pregnant? | ❑ Yes | ❑ No |

| ALLERGIES: Medicines: | Environmental or other: |
| --- | --- |
| | |

List all non-prescription, prescription, and herbal medications you take. Attach a separate sheet if necessary.

| Medication name | Amount and how often each time | Why you take it |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**If your answer is Yes to any of the questions below, please use the spaces provided to tell us more about your experience.**

Do you have any physical health conditions that may prevent you from participating in outdoor or indoor physical activity? ☐ Yes ☐ No

Have you ever experienced or been diagnosed with anxiety? ☐ Yes ☐ No

Have you ever cut yourself, or hurt yourself in other ways? ☐ Yes ☐ 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 | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Tobacco | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Marijuana | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Cocaine | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Glue/inhalants | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Methamphetamines (ecstasy, MDMA) | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Fentanyl | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Opiates (e.g. oxy, percs, hydro, codeine) | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Heroin | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Benzodiazepines (e.g. benzos, goofballs, roofies, Valium, etc.) | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Barbiturates (e.g. barbs, downers, sleepers, reds, etc.) | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Medicines (e.g. pain reliever, antihistamine, cough syrup) | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ Swallowed | | | | |
| Other<br>Please name: | ❑ Yes | ❑ No | ❑ Smoked ❑ Injected<br>❑ Snorted ❑ 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:

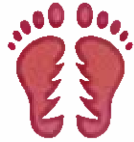
Lawyer name:

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**

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**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**<br>**2027 Highway 540, Little Current, Ontario**<br>**Tel. 705-370-5307 \| Fax. 705-370-5308** | **Participant Consent Form**<br>**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 | ☐ | ☐ | ________ |
| 2. Discharge Summary | ☐ | ☐ | ________ |
| 3. Reports | ☐ | ☐ | ________ |
| 4. Confirmation of Attendance/Completion | ☐ | ☐ | ________ |
| 5. Legal Status (i.e. court cases, parole, probation) | ☐ | ☐ | ________ |
| 6. All information re: Methadone/Suboxone | ☐ | ☐ | ________ |
| 7. Traditional Program/Resource | ☐ | ☐ | ________ |
| 8. Other: ____________________ | | | |
| ____________________ | ☐ | ☐ | ________ |

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:__________________