

**SASKATCHEWAN NNADAP
TREATMENT SERVICES
APPLICATION FOR TREATMENT
SERVICES**

(Version 2 / October 2002)

This application is the first step required to prescreen applicants for adult treatment at any of the NNADAP facilities listed below. Additional information maybe required by individual centres before a decision on acceptance is made.

New Dawn Valley Centre

Box 400
Fort Qu' Appelle, Sask
S0G-1S0
Ph: (306) 332-5637
Fax: (306) 332-4815
Email: ndvc@sasktel.net

Cree Nation Treatment Haven

Box 340
Canwood, Sask
S0J-0K0
Ph: (306) 468-2072
Fax: (306) 468-2758
Email: cree.nations@sk.sympatico.ca

Mistahey Musqua

Box 404
Loon Lake, Sask
S0M-1V0
Ph: (306) 837-2184
Fax: (306) 837-4414
Email:
mistahey.musqua@sk.sympatico.ca

Athabasca Outpatient Project

Box 162
Black Lake, Sask
S0J-0H0
Ph: (306) 284-2124
Fax: (306) 284-2173
Email:

Clearwater River

Box 5010
Clearwater River, Sask
S0M-3H0
Ph: (306) 822-2033
Fax: (306) 822-2750
Email: crdnt@sk.sympatico.ca

Ekweskeet

Box 280
Onion Lake, Sask
S0M-2E0
Ph: (306) 344-2094
Fax: (306) 344-4805
Email: ekweskeet@sk.sympatico.ca

Sakwatamo Lodge

Box 3917
Melfort, Sask
S0E-1A0
Ph: (306) 864-3631
Fax: (306) 864-2204
Email: sakwatamo@sk.sympatico.ca

**Saulteaux Healing & Wellness
Centre**

Box 868
Kamsack, Sask
S0A-1S0
Ph: (306) 542-4110
Fax: (306) 542-32
Email:

*** Email copies of this form are available for electronic transmission. Please return completed form to the centre you are applying to.*

SASKATCHEWAN NNADAP TREATMENT SERVICES APPLICATION FOR TREATMENT SERVICES

This application is the first step required to prescreen applicants for adult treatment at any of the NNADAP facilities listed below. Additional information may be required by individual centres before a decision on acceptance is made.

Case Number (centre use ONLY): _____	Date of Application: _____
--------------------------------------	----------------------------

First Name: _____	Last Name: _____
AKA (alias): _____	
SIN #: _____	Health Card #: _____
Age: _____	Date of Birth: _____
First Nation: _____	Gender: _____ Marital Status: _____
Band #: _____	Address: _____
Treaty #: _____	Prov: _____ Phone: _____

Substance Use/Social History

Substances Used:

_____ Alcohol	_____ Inhalants	_____ Prescription Drugs _____ (type)
_____ Marijuana	_____ Heroin	_____ Morphine
_____ Crack Cocaine	_____ Talwin & Ritalin	_____ Other: _____
_____ Cocaine	_____ Ecstasy	

Which is the drug of choice? _____

What is the pattern of use? (please circle) daily binges weekly other

Which of the following have been negatively affected by the use:

_____ School Attendance	_____ Legal Situation
_____ Family Relationships	_____ Psychological Health
_____ Physical Health	_____ Other: (please explain)
_____ Employment	_____

Is there any history of drug use in the family of origin? If yes please explain:

Do you have any history of gambling problems or any other process addiction? Yes/No Explain:

Are you now or have ever been an IV drug user? Yes/No Type: _____

As of today when was your last use of any substance? _____

What type? _____ How much? _____

What is the longest period you have been able to stay free of substances: _____
When? _____

If changing your life becomes uncomfortable for you, how prepared are you to continue treatment? _____

List the reasons you feel you were able to remain clean that length of time: _____

Why are you seeking treatment now?

- _____ To get children back
- _____ As a requirement of my employer
- _____ Court ordered (see legal)
- _____ Other, please explain

Have you attended treatment previously? Yes/No If yes, where and when? (list all):

Do you have custody of any minor children? Yes / No

What are the plans for your children while you seek treatment? _____

Did you or any member of your family attend residential school? Yes / No

Please detail relationship (ie mother) and years attended if available. _____

Are you presently involved with any other agencies (ie social services) that may provide continued support to you when you complete treatment? Yes / No _____ (agency name)

May we involve these agencies in your case planning? Yes / No

Contact name: _____ Phone Number: _____

Legal History

Have you ever been convicted of a crime? Yes /No

If yes, please list convictions and dates: _____

Were you under the influence of any substances at the time of the above crimes? Yes /No

If yes, please explain: _____

Do you have any current outstanding charges? Yes / No

If yes, what are you charged for? _____

When and where is your next court appearance? _____

What is your current legal status? Parole Probation Bail Temporary Absence N/A

*** You may be required to submit a formal list of past convictions prior to individual centre acceptance*

Medical History

Do you have any medical history of seizures, allergies, heart conditions, or diabetes? Yes /No

Explain: _____

Have you ever undergone a mental Health Assessment? Yes / No

If yes, would you be willing to share a copy of the assessment with our centre? Yes / No

Who provided the assessment and when? _____

If female, are you currently pregnant? Yes / No Estimated Due Date: _____

If yes, please provide details as to length of pregnancy, prenatal caregiver, and any substance use that has taken place during the pregnancy? _____

Are there any other medical concerns we should be aware of? _____

Referral Source Questions

Referral Name: _____ Position _____

Mailing Address: _____

Phone: _____ Fax: _____ Email: _____

How long have you been involved with this client? _____

To this point, how have you been involved in the client's recovery? _____

Has the client attended any intervention activities in your community? Yes / No If yes, provide details and dates. _____

In your opinion, what are the most important areas this client needs to address during treatment? _____

What services will you provide related to continuing care and treatment after care upon program completion?

In your opinion what is motivating this client to seek treatment at this time? _____

Are there any other services currently involved in trying to assist this client? _____

Are you aware of any factors in this clients life (medical conditions or legal charges) that may pose a threat to other clients in residential treatment? _____

Has this client been referred to and denied treatment at any other centre? Yes / No If yes, please explain: _____

Do you have any information or reasons to believe this client may have difficulties related to FAS or FAE? Yes/No. If yes, please explain: _____

Have you completed a SASSI or other form of addictions assessment? Yes / No

If yes, please include a copy with this application.

Referral Agent Oath:

I certify that the information contained in this section is true to the best of my knowledge.

Signature _____

Date: _____

Please fax or mail back to the treatment centre to which you are making the referral. Add additional pages as required.

