

Centre Walgwan Center

Admission Request for Residential Program



(To activate a check box, double-click, in the popup menu, pick activate the check box. Save document under client's name and send to walgwan@globetrotter.net)

A) Please complete the following material

- | | | | |
|---|--------------------------|-------------------------|--------------------------|
| Admission Request Form – All 5 sections | <input type="checkbox"/> | Smoking Consent Form | <input type="checkbox"/> |
| Consent Form | <input type="checkbox"/> | Commitment to Care Form | <input type="checkbox"/> |
| Other Clinical Reports if available | <input type="checkbox"/> | | |

B) Please ensure that all following documents are included and signed by the parties required

	Is Included	Will follow	Is not available
Birth certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Band # / Beneficiary #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Insurance card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scholastic information and school report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Info on the consumption of substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Court Order / Alternative measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consent form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (reports from previous treatments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivation letter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ensure that the minimal clothing inventory has been completed, indicating the client shall be admitted with all required clothing.

If you have any additional information you think would be helpful, or if you require more room than what has been allotted on the forms, please attach additional pages.

C) Mail, email or fax the above material to the attention of:

Intake Worker		
Centre Walgwan Center		
75 School Street		
Gesgapegiag (Québec) G0C 1Y1		
Tel.: 418 759-3006	Fax: 418 759-3064	walgwan@globetrotter.net

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SECTION 1. IDENTIFICATION

1.1. CLIENT IDENTIFICATION

Name: _____ Sex: F M
 Date of Birth: (DD/MM/YY) _____ Indian Status Yes No
 Band Name: _____ Nation: _____
 Living : On reserve Off reserve
 Band number _____ Beneficiary _____
 (10 digits) (if applicable)
 Spoken language _____
 Written language _____
 Address of residence _____
 Postal Code _____ Phone number: _____
 Health Care # _____ S.I.N. # _____
 Contact person in case of emergency, Name: _____
 Relationship with client: _____
 Phone Number-s: _____

1.2. FAMILY IDENTIFICATION

1.2.1 Type of family **Biological family** **Adoptive family**

NAME	ADDRESS	PHONE NUMBER	
Father:			
Mother:			
Sibling 1: (Oldest)		Age:	
Sibling 2 (Next oldest)		Age:	
Sibling 3		Age:	
Others?			

1.2.2. Who is presently appointed as Legal Guardian for this client?

Name: _____ Phone Number: _____
 Address: _____
 Relationship to client: _____
 (parents, grand-parents, uncle, etc.)

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1.2.3. Who does the client live with at the present time?

Biological family Adoptive family Legal Guardian Other? _____

If other, please name person or institution: _____

Address: _____

Phone # _____

Please list the persons in the household if different from 1.2.1. at the moment of reference

Name of person	Relationship with client if any

1.2.4 Does the client have any children? Yes No

If yes, please indicate the age of the child or children, where and with whom the child or children reside, and give details about the relationship between the client and his/her child or children?

1.3. RESOURCE IDENTIFICATION:

1.3.1. Referral Sources

Assessor's name: _____

Relationship to client: _____

Agency's name: _____

Address: _____

Province: _____ Postal Code: _____

Phone #: _____ Fax #: _____

Name of Aftercare counselor: _____

Relationship to client: _____

Agency's name: _____

Address: _____

Province: _____ Postal Code: _____

Phone #: _____ Fax #: _____

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1.3.2. Please give name and phone numbers of all other workers involved in this admission:

Social worker:	_____	Phone #:	_____
Psychologist:	_____	Phone #:	_____
Probation Officer:	_____	Phone #:	_____
Others:	_____	Phone #:	_____

1.3.3. Please identify the resources that are available in the client's community:

N.N.A.D.A.P. Worker	<input type="checkbox"/>	Youth Worker	<input type="checkbox"/>
Social Worker	<input type="checkbox"/>	Elder	<input type="checkbox"/>
Community Health Representative	<input type="checkbox"/>	Others?	_____

1.3.4. Please identify all services used by client in the past, and explain for what purpose:

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SECTION 2. PROFILES

2.1. CLIENT'S PROFILE

2.1.1. Please identify which of the following conditions apply to the client:

Solvent abuse	<input type="checkbox"/>	Alcohol abuse	<input type="checkbox"/>	Other substance abuse	<input type="checkbox"/>
Past physical abuse	<input type="checkbox"/>	Past sexual abuse	<input type="checkbox"/>	Conflict with parent	<input type="checkbox"/>
Aggressive behavior	<input type="checkbox"/>	Assault behavior	<input type="checkbox"/>	Sexual offender	<input type="checkbox"/>
Prostitution	<input type="checkbox"/>	Self-mutilation	<input type="checkbox"/>	Suicide attempts	<input type="checkbox"/>
Running away	<input type="checkbox"/>	Illegal activities	<input type="checkbox"/>	Suicidal ideations	<input type="checkbox"/>
Grade retention	<input type="checkbox"/>	School drop out	<input type="checkbox"/>	Peer's solvent abusers	<input type="checkbox"/>
				Wandering around	<input type="checkbox"/>

Specify _____

2.1.2. Do the above occur mainly under the influence of substances? Yes No

If yes, clarify _____

2.1.3. Aggressive and assault behaviour: Specify at what age, circumstances and towards whom this behavior took place and if the client was under the influence or not:

2.1.4. Past sexual and physical abuse: Specify in which context these events occurred, whether they are still going on today and at what age they began:

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2.1.5. Self-mutilation, suicide attempts and suicidal ideation: Specify at what age incidents occurred, what methods were used for mutilation or attempted suicide and what triggered this type of behaviour. As well, please explain if the client was under the influence or not and how many attempts were made.

2.1.6. Did the client get any counselling in regards to the above conditions? Yes No

If yes, provide name and phone number of counsellor

Name: _____ Phone #: _____

Is report of counselling included? Yes No

2.1.7. Has the client ever attended a treatment centre for problems related to substance abuse?

Yes No If yes, provide information about the last treatment center:

Name: _____ Phone #: _____

Date: _____ Is report of last treatment included? Yes No

2.1.8. Does the client practice a specific religion? Yes No

Which one? _____

2.1.9. Has the client ever practiced a native traditional approach? (For example: sweat lodge, healing circle, spiritual guide, elder, traditional camping, etc.) Yes No

2.1.10. Are there restrictions imposed by the family or the client about using a traditional approach?

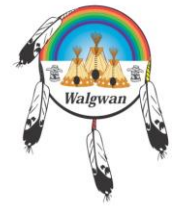
2.1.11. Solvent and other substance abuse information
Please indicate all known substances used by the client:

- | | | | |
|--|--|--|--------------------------------------|
| Gasoline <input type="checkbox"/> | Butane <input type="checkbox"/> | Cleaning fluids <input type="checkbox"/> | Diesel fuel <input type="checkbox"/> |
| Typewriter correction fluid <input type="checkbox"/> | Nail polish <input type="checkbox"/> | Paint remover <input type="checkbox"/> | Cement <input type="checkbox"/> |
| Nail polish remover <input type="checkbox"/> | Hair spray <input type="checkbox"/> | Propane <input type="checkbox"/> | Deodorants <input type="checkbox"/> |
| Spray paint <input type="checkbox"/> | Glue <input type="checkbox"/> | Room deodorizer <input type="checkbox"/> | |
| Prescribed medication <input type="checkbox"/> | Specify which one <input type="checkbox"/> | | |

Over counter drugs (Tylenol, cough syrup, etc.) Which ones? _____

Alcohol Marijuana, weed or hashish Cocaine PCP L.S.D

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2.1.12. List substances used in order of preference

Substance	Date		Frequency of use (How often)	Quantity consumed (How much)
	First use	Last use		

2.1.13. Did the client's usage of substances increase over time? Yes No

2.1.14. At what age did the client used the most? _____

2.1.15. What elements trigger use of substances?

2.1.16. What are the reasons given by the client for using substance?

- | | | | | | |
|-------------------------|--------------------------|---------------------------------|--------------------------|-----------------------|--------------------------|
| To make friends | <input type="checkbox"/> | To do like my friends | <input type="checkbox"/> | To be part of a group | <input type="checkbox"/> |
| Because nobody likes me | <input type="checkbox"/> | Because nobody takes care of me | <input type="checkbox"/> | To have fun | <input type="checkbox"/> |
| To forget my problems | <input type="checkbox"/> | Because nobody understands me | <input type="checkbox"/> | | |
| Other | <input type="checkbox"/> | _____ | | | |

2.1.17. Has the client ever experienced a period of abstinence? Yes No

If yes, explain when this period occurred and how long it lasted

What methods did the client use in order to reach that level of abstinence at the time?

2.1.18. Indicate the effects that using the substances has on the client's life:

- | | | | | | |
|---|--------------------------|--|--------------------------|--------------------------|--------------------------|
| Loss of friends | <input type="checkbox"/> | Suspension from school | <input type="checkbox"/> | Aggressive behaviour | <input type="checkbox"/> |
| Feelings of regrets | <input type="checkbox"/> | Arrest for committing an illegal act | <input type="checkbox"/> | Feelings of shame | <input type="checkbox"/> |
| Loss of appetite | <input type="checkbox"/> | Hurt somebody you care about | <input type="checkbox"/> | Experienced a blackout | <input type="checkbox"/> |
| Feelings of guilt | <input type="checkbox"/> | Experienced suicidal attempt | <input type="checkbox"/> | Forgetting what happened | <input type="checkbox"/> |
| Being afraid without knowing why | <input type="checkbox"/> | Becoming sick after stopping to sniff for a couple of days | <input type="checkbox"/> | | |
| Having to be taken to the hospital | <input type="checkbox"/> | Seeing or hearing things that were not really there | <input type="checkbox"/> | | |
| Having been in dangerous situations or in an accident | <input type="checkbox"/> | | | | |

Comments: _____

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2.2. FAMILY'S PROFILE

2.2.1. Please provide information known about client's father and mother

YES =

NO =

Don't know =?

Biological

Adoptive

	Father	Mother	Father	Mother
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>			

Please specify: _____

2.2.2. Please provide information known about client's families

YES =

NO =

Don't know =?

Biological Family

Adoptive Family

Current Live-in Family

Suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Matrimonial violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poverty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>		

Please specify _____

2.2.3. List the significant people that are most supportive of client's solvent treatment.

Name: _____ Relationship with client: _____

Name: _____ Relationship with client: _____

Name: _____ Relationship with client: _____

2.2.4. Please provide general information about the relationship between the client and his/her live-in family members:

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SECTION 4. MEDICAL

4.1. CLIENT'S MEDICAL INFORMATION

This section can be filled out by a doctor or a certified nurse

4.1.1. Identification of physician or nurse:

Name of Clinic: _____
 Name of medical examiner _____ Title: _____
 Postal Code: _____ Phone #: _____

4.1.2. Client's information:

Name: _____
 Client's File Number: _____ Health Insurance #: _____
 BP: _____ Weight: _____ Height: _____
 Are immunization up to date? Yes No Unknown
 If not, what is presently required? _____

4.1.4. If appropriate indicate:

Date of last menstrual period: _____

Is client pregnant? Yes No If yes, how many weeks? _____

4.1.5. Physical examination by:

_____ Date of exam: _____

	Normal	Abnormal	Specify
<input type="checkbox"/> Gastro-intestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Genito-urinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Cardio-vascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Musculo-skeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Reticulo-endothelial	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Blood, lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Ear, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Hair, skin, nails	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other health problems

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Enuresis | <input type="checkbox"/> Learning problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | (Disabilities) |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> STD | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Mental deficit |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Difficulty in concentrating | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Poor hygiene |
| <input type="checkbox"/> Lice and nits | <input type="checkbox"/> Skin problems | | |

Please note that if the client is currently under prescribed medication, he/she should arrive at the Center with a written prescription. We will then ensure to submit the prescription to the pharmacy to get his/her medication.

If necessary, please provide information on treatment or issues on a separate sheet.

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4.1.6. Mental Health

Does client have mental health problems? Yes No Unknown
 If yes, please specify: Fear, distress Depression Suicidal ideation Suicidal attempt
 Paranoia Others: _____

Please, provide information concerning the client’s mental problems, such as what triggered them, the dates and/or periods where they occurred, the duration and methods used to control them, etc.

Is the client presently under the care of a professional? Yes No

If yes, Name of specialist: _____
 Reason to follow up: _____

Please provide the report of the specialist – Is report included? Yes No

If the client is not under care, would you suggest a professional follow-up based on your evaluation?
 Yes No If yes, for what reasons? _____

4.1.7. Medication

Does the client take medication? Yes No Unknown If yes, please list:

Medication	Start Date / End Date	Dosage	Reason

4.1.8. Dietary Restrictions:

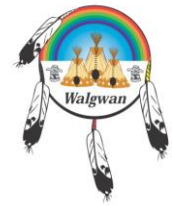
Does client have dietary restrictions? Yes No Unknown If yes, please list:

4.1.9. Please provide all other relevant medical information:

Date client was seen: _____

Signature of specialist or authorized nurse: _____

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SECTION 5. LEGAL STATUS

This Information Refers to the Young Offenders and Youth Protection Acts

5.1. CLIENT'S LEGAL STATUS:

Current Legal Status **NO Legal Status** **OR please provide all details required below as applicable**

Youth Protection Act <input type="checkbox"/>	Young Offenders' Act <input type="checkbox"/>
Article 38, A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> Alternative Measures: <input type="checkbox"/> Court Order: <input type="checkbox"/> Ordinance #: _____ Article #: _____ Expiration date: _____	Alternative Measures: <input type="checkbox"/> Court Order: <input type="checkbox"/> Ordinance #: _____ Article #: _____ Description: _____ Expiration date: _____ Offence: _____

***** If Young Offender or Youth Protection Act, please include all necessary legal documentation *****

5.1.1. Placement History information in relation to Young Offender OR Youth Protection OR Voluntary Placement

Date and Duration of Placement	Residence	Caregiver's Name

5.1.2. Court Appearance: Is there a date where the client must appear in court? Yes No

If yes, please provide date of appearance: _____

Reasons: _____

5.1.3. Contacts: Is there anyone who is forbidden from contacting this client? (Court injunction, limitations, or...)

Name: _____ Relationship to the client _____

Name: _____ Relationship to the client _____

Please include Pre-Sentence Report, Court Decisions, Probation Report and other relevant report in annex

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CONSENT FORM

I, _____ on this date _____
(Parent /Legal Guardian) (Today's date – dd / mm / yy)
authorize the Executive Director of Centre Walgwan Center or his delegate to provide rehabilitation treatment for _____
(Name of Client) (Date of birth)
for a possible period of up to three and a half (3 ½) months in residential care.

I understand that I am also:

- Consenting to psychological or psychiatric assessment
- Consenting to medical assessment and treatment
- Allowing the Center to transmit & receive personal information concerning the clinical files to and from:
Social Services, Psychological Services, N.A.A.D.A.P. Worker, Youth Center
Psychiatric Services, Schools, and others as required.

I understand that no information will be released to any other person without my written consent except to persons directly involved with my treatment.

I can withdraw or amend my consent to the release of information at any time.

Signature of the client _____
Signature of the parent _____
Or Legal Guardian _____
Signature of the referent _____
Start date of consent _____ End date of consent _____
(30 days after treatment)

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COMMITMENT CONTRACT

Following the admission of _____ , the day of

_____, I, _____

(relationship with youth) _____ , commit myself to support him or her

during his or her stay at the Centre Walgwan Center and also to get information about his progression in his program.

I will keep in contact with the youth by phone call every:

We are suggesting calling after 6 o'clock at the following number 418 759*3075. There might be special authorization concerning hours of call according to the working schedule of the counsellors.

Sign on : _____ , in Gesgapegiag (Centre Walgwan Center)

Client's name: _____

Intervener's name: _____

Parent's name: _____

Significant person's name: _____

Name of the employee at Centre Walgwan Center : _____