

CENTRE WALGWAN CENTER ADMISSION REQUEST FORM



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.

Client Information											
Date Application received by Community Worker:			Click or tap to enter a date.		Date Application received by Treatment Center			Click or tap to enter a date.			
Surname		First Name			Nickname						
Date of Birth		Click or tap to enter a date.		Age	Sex	Choose an item.	Provincial Health Card				
Client Address:				Client Phone:							
Language Spoken			Language Preferred			Language Understood					
Status Indian:		Treaty Number:			Band Name:						
Biological Parents											
Guardian Name			Guardian Address			Guardian Phone					
Place of Employment				Phone							
Social Services Involvement											
Agency Name					Phone						
Worker Name					Client Status			Choose an item.			
Family Relationships											
Does client have dependent children?							Choose an item.				
If yes, do they have access to adequate childcare while in treatment?							Choose an item.				
Are the children in care?							Choose an item.				
Does the client have other dependants?							Choose an item.				
Provide information on client's children or other dependants											
Name			Age			Relationship					
Who does your client live with?			Choose an item.			Who client is closest to?					
How does your client get along with his/her family members?											
Does client have any siblings?											
Name			Age	Health Status			Lives with				
							Choose an item.				
							Choose an item.				
							Choose an item.				
							Choose an item.				
							Choose an item.				
							Choose an item.				
							Choose an item.				
							Choose an item.				
Maternal											
Paternal											
Does your client have any close friends?				Choose an item.			If so, who?				
Does she/he have a boyfriend or girlfriend?				Choose an item.			Is he/she sexually active?		Choose an item.		

Does he/she talk to any elders?	Choose an item.	Is he/she willing to listen	Choose an item.
Religious Beliefs			
Other			
Family Supports			
Family Strengths			
Education			
Does your client go to school?	Choose an item.	Does your client like school?	Choose an item.
Highest grade completed			
Name of school		Last year attending school	
Medical History			
Does your client have any medical problems?	Choose an item.	Does he/she require a consent form?	Choose an item.
Please identify			
Family doctor's name		Phone	
Is your client currently on medication?	Choose an item.	Does he/she have allergies?	Choose an item.
Legal Problems			
Has your client ever been in trouble with the law?		Choose an item.	
Please explain			
Was alcohol or any other substances: such as sniff or drugs involved during your client's legal problems?			Choose an item.
Please explain:			
Is your client currently on probation or on a court order?	Choose an item.		
Name of probation officer		Phone	Fax
Probation Order	From	Click or tap to enter a date.	To
Conditions	Click or tap to enter a date.		
Copy attached?	Choose an item.	Has your client been involved with any substances abuse?	Choose an item.
Chemical Use History			
At what age did your client start sniffing?	Choose an item.	At what age did your client start alcohol?	Choose an item.
At what age did your client start using other drugs?	Choose an item.	Does anyone else in his/her family use solvent/substances?	Choose an item.
If so, who else?			
Does he/she use solvents/substances with others or by him/herself?	Choose an item.	Does your client usually sniff or huff at home?	Choose an item.
Does your client usually sniff or huff at a friend's house?	Choose an item.	Does your client usually sniff or huff at school?	Choose an item.
Does your client usually sniff or huff in an abandoned building?	Choose an item.	Does your client usually sniff or huff in an abandoned car or truck?	Choose an item.
Does your client usually sniff or huff at a party?	Choose an item.	Does your client usually sniff or huff outdoor?	Choose an item.
Is there any other place your client usually sniffs or huffs?			
Has your client ever lost friends because of sniffing or huffing?	Choose an item.		
Has your client ever gotten into any physical fights when using?	Choose an item.		
Has your client ever caused serious injuries to other?	Choose an item.		

Please explain:	
Does the client have any medical, physical, psychological, emotional problems because of the use of solvents/substances?	Choose an item.
Please explain:	
Does he/she feel that they have control over their use of solvents/substances?	Choose an item.
Has he/she ever considered reducing or quitting?	Choose an item.
Has he/she ever been in any previous treatment for their use of solvents/substances?	Choose an item.
Where have they had previous treatment?	
When have they had previous treatment?	
How long did the client stay in the program? (in months)	Choose an item.
Has client participated in a non-residential/community based substance abuse and/or mental health program?	Choose an item.
If yes, what type of program?	
Psychological Functioning	
Has your client ever spoken or written about killing him/her self?	Choose an item.
Has your client ever attempted to kill him/her self?	Choose an item.
How many times?	Choose an item.
How did she or he attempt to kill him/her self?	
Has the client frequently gone off on their own when depressed or unhappy?	Choose an item.
Is the client sad/unhappy?	Choose an item.
How often is the client sad/unhappy?	Choose an item.
Is there any known history of sexual abuse?	Choose an item.
Is there any known history of physical abuse?	Choose an item.
Is there any known history of emotional abuse?	Choose an item.
Please explain: (i.e. at what age, has it been reported and what is the outcome or the current status)	
Is there any history of family violence that this child may have been witness to?	Choose an item.
Please explain:	
When the client is in a sober state has he/she communicated with spirits that no one else can see or hear?	Choose an item.
Are these communications positive or negative experiences for the client?	Choose an item.
Please explain:	
Are there times when people are unable to communicate with the client?	Choose an item.
Please explain:	
Has your client ever had any psychological testing or counseling?	Choose an item.
If so, for what purpose?	
Outside Resources	
Are there any other agencies involved with your client and his/her family?	Choose an item.
If so, which ones and what services do they provide? (for example, NNADAP, CHR, CFS)	
Family Activities/Practices (What do you see as a family?)	
Family Roles/Relationship (How do they interact with each other?)	
Status in the community (How is the family perceived in the community?)	
What type of belief system is practiced?	
How does he/she spend his/her leisure time?	
Who are the other support people involved with the family? (example, elders, extended family, community groups, community workers, CHR, NNADAP, CWPW)	
Is the client aware of the effects of solvents/substances?	Choose an item.
Is the client's family aware of the effects of solvents/substances?	Choose an item.

Is the client's community worker aware of the effects of solvents/substances?	Choose an item.
What steps does the family want to take to address the problem?	
Has anyone in his/her family received treatment for solvents/substances abuse?	Choose an item.
Please explain:	
Are the parents supportive of their child receiving treatment? (Refer to Referral Agent Agreement and Parental Consent Form)	Choose an item.
Please explain:	
Upon the child's completion of the program, what type of support system do you see as effective/useful to help maintain a clean lifestyle for self/child?	
Are the extended family members supportive of the family seeking help and/or treatment for themselves or their child?	Choose an item.
Please explain:	
Would the family be willing to come to our Treatment Center to observe the program in action as part of the intake process?	Choose an item.

The questions in **RED** in that form are mandatory.

Save your document and send it to Ashley@walgwan.com



CONSENT TO CARE 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 period of:

- Whole program (14 weeks)**
 Prevention Program (4 weeks)

I understand that I am also consenting

- 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)

COMMITMENT TO CARE 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 or her 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 : _____



CONSENT TO WEARING NICOTINE PATCHES

Policy on Smoking Cigarette

It is forbidden to smoke at Walgwan Center. Youth upon their admission to the Centre cannot have cigarettes, lighter or matches on them at all times. Smokers who enter the Walgwan Center will be strongly encouraged to participate in a program to quit smoking as part of their treatment program. Thus, any youth older than 14 years can get and use nicotine patches with the consent of their parents or their legal guardians.

Please sign the following Consent Form:

As a legal guardian, I consent to allow my youth to obtain and wear nicotine patches:

Parent or Guardian _____ Youth _____

Date _____

I agree to obey the above rule.

Signature of Client _____

Date : _____



Consent to Disclose and to Obtain Information¹

I, the undersigned _____

Born on: _____

Consent that _____
(Name of the institution, organization or professional, or name and qualification of the person)

Disclose the following information or documents:

To: _____
(Name of the institution, organization or professional, or name and qualification of the person)

Obtain the following information or documents:

From: _____
(Name of the institution, organization or professional, or name and qualification of the person)

Contained in the file of:

Family Name

Given Name

Date of Birth

Address (Number, street, city, postal code)

For the following reasons:

(Specify the reasons for the disclosure)

This consent may be withdrawn at any time.

Signed at _____, this _____
(day/month/year)

Signature

Witness' signature and name in block letters

¹ Note: This form must be signed by:

- a client of 14 years or older
- a person exercising parental authority if the client is less than 14 years old



hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Centre Walgwan Center, its administrators, supervisors and employees or volunteers, associated with any program or activity.

NOTE: Centre Walgwan Center cannot continually monitor compliance of its clients or any limitations imposed upon them by parents or medical providers. Please list any restrictions imposed on your child and counsel your child to comply with those restrictions.

List participant restrictions, if any:

None

Participant's signature _____ Date _____

Parent/Guardian printed name _____

Parent/Guardian signature _____ Date _____

Area Code and telephone number (Best contact and Emergency contact)

Email (for use in sharing more details about the trip or activity)

Contact the adult leader with any questions

Name _____ Phone _____ Email _____





CONSENT TO IMMUNIZATION

I, _____ hereby consent to the influenza vaccination for
(Parent/Guardian's Name)
for _____
(Youth's Name)

while in treatment at Centre Walgwan Center in accordance with the Occupational Health and Safety Standards.

I understand that only a qualified medical professional shall administer the vaccination.

(Parent/Guardian's Signature)

Date: _____

CONSENT TO VIDEO MONITORING



The Centre Walgwan Center uses, "Video Monitoring" as an enhancement to the safety and security of the clients and its facilities. Confidentiality is maintained however video may be shared for criminal investigations.

I, _____ (Parent/Guardian) understand that video monitoring at Centre Walgwan Center is used for the safety and security of my child, and consent to video monitoring.

Signature

Date



ABSENT WITHOUT LEAVE PROCEDURE FORM

Client's Name: _____ Alias: _____

Date of Birth: _____ Tattoos/Scars _____

Are there any court orders currently in effect? Yes No

If yes, what is the status and who is the contact person?

Physical Description		Insert Client's Picture
Hair color:	_____	
Eye color:	_____	
Height:	_____	
Weight:	_____	

Notification Procedure:

Referring Worker is to be notified

- Immediately
- After 4 hours
- After 8 hours

Parents/Guardian are to be notified:

- Immediately
- After 4 hours
- After 8 hours

In the event that Parents/Guardians are not available, the following people may be notified:

Name: _____ Name: _____

Address: _____ Address: _____

Phone # _____ Phone # _____

Relationship _____

Relationship _____

** I understand the Centre Walgwan Center will make every attempt to ensure the safety of my child at all times. In the event of an AWOL, I understand the treatment center's personnel will allow sufficient time for my child to return to the center. Any unplanned leave that is longer than four hours will be considered an "AWOL", and will be followed up by a formal report to the referring worker.

Referral Worker's Signature _____

Parent/Guardian's Signature _____