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	☐	Smoking Consent Form	☐
Consent Form	☐	Commitment to Care Form	☐
Other Clinical Reports if available	☐		

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

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

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

Centre Walgwan Center

Admission Request for Residential Program

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.)

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 #: _____

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	☐	Youth Worker	☐
Social Worker	☐	Elder	☐
Community Health Representative	☐	Others?	_____

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

_____

_____

_____

_____

_____

_____

SECTION 2. PROFILES

2.1. CLIENT'S PROFILE

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

Solvent abuse	☐	Alcohol abuse	☐	Other substance abuse	☐
			Specify	_____	
Past physical abuse	☐	Past sexual abuse	☐	Conflict with parent	☐
Aggressive behavior	☐	Assault behavior	☐	Sexual offender	☐
Prostitution	☐	Self-mutilation	☐	Suicide attempts	☐
				Suicidal ideations	☐
Running away	☐	Illegal activities	☐	Peer's solvent abusers	☐
Grade retention	☐	School drop out	☐	Wandering around	☐

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:

_____

_____

_____

_____

_____

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	☐	Butane	☐	Cleaning fluids	☐	Diesel fuel	☐
Typewriter correction fluid	☐	Nail polish	☐	Paint remover	☐	Cement	☐
Nail polish remover	☐	Hair spray	☐	Propane	☐	Deodorants	☐
Spray paint	☐	Glue	☐	Room deodorizer	☐		
Prescribed medication	☐	Specify which one					
Over counter drugs (Tylenol, cough syrup, etc.)	☐	Which ones?					

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

2.1.12. List substances used in order of preference

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

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 ☐ To do like my friends ☐ To be part of a group ☐
Because nobody likes me ☐ Because nobody takes care of me ☐ To have fun ☐
To forget my problems ☐ Because nobody understands me ☐
Other ☐ _____

_____

_____

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

_____

_____

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	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐
Mental disorders	☐	☐	☐	☐
Medical problems	☐	☐	☐	☐
Others	☐			

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	☐	☐	☐
Matrimonial violence	☐	☐	☐
Poverty	☐	☐	☐
Family unemployment	☐	☐	☐
Substance abuse	☐	☐	☐
Others	☐	☐	☐

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:

_____

_____

_____

_____

SECTION 3. EDUCATION

3.1. SCHOOL INFORMATION

3.1.1. Does the client go to school? Yes ☐ No ☐

If yes, specify the type of school Residential school ☐ Boarding school ☐ Public school ☐

On reserve ☐ Off reserve ☐

3.1.2. Last school attended and date last attended Date: _____

Name of school: _____

Contact Name: _____ Position: _____

Address: _____

Phone number: _____ Please include last school report ☐

3.1.3. Please give details concerning the relationship and general behaviour of the client with people in authority at school?

_____

_____

_____

3.1.4. Subject information:

Preferred subjects: _____

_____

Difficulties with subjects: _____

_____

3.1.5. Has the client ever been employed? (Ex. Summer Job, etc.) Yes ☐ No ☐

Job: _____ Employer: _____

Contact: _____ Phone: _____

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
☐ Gastro-intestinal	☐	☐	
☐ Genito-urinary	☐	☐	
☐ Respiratory	☐	☐	
☐ Cardio-vascular	☐	☐	
☐ Musculo-skeletal	☐	☐	
☐ Reticulo-endothelial	☐	☐	
☐ Blood, lymphatic	☐	☐	
☐ Abdomen	☐	☐	
☐ Thyroid	☐	☐	
☐ Appearance	☐	☐	
☐ Ear, nose, throat	☐	☐	
☐ Hair, skin, nails	☐	☐	

Other health problems

☐ Eating problems	☐ Sleeping problems	☐ Enuresis	☐ Learning problems
☐ Asthma	☐ Diabetes	☐ Epilepsy	(Disabilities)
☐ Allergies	☐ STD	☐ Hyperactivity	☐ Mental deficit
☐ Agitation	☐ Difficulty in concentrating	☐ Hallucinations	☐ Vision problems
☐ Hearing problems	☐ Coordination problems	☐ Poor memory	☐ Poor hygiene
☐ Lice and nits	☐ 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.

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: _____

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 ☐	**Young Offenders' Act** ☐
Article 38, A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ Alternative Measures: ☐ Court Order: ☐ Ordinance #: Article #:	Alternative Measures: ☐ Court Order: ☐ Ordinance #: Article #: Description:
Expiration date:	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

Centre Walgwan Center

Admission Request for Residential Program

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)

SMOKING CONSENT

Smoking Policy

Smoking within the Centre Walgwan Center is not permitted. The designated smoking areas are outside; 50 feet from the building, in accordance with the Quebec tobacco laws. Youth will not be permitted to carry cigarettes, lighters or matches with them at any time. Cigarettes and lighters will be safeguarded by staff. Smoking is only allowed at scheduled breaks; four times per day. The staff at the Walgwan Center will oversee the distribution of cigarettes during the scheduled smoke breaks.

Smokers entering the Walgwan Center will be encouraged to participate in a tobacco cessation program as part of their rehabilitation.

Background

There are numerous factors that prompted the Centre Walgwan Center to leave the decision of smoking up to the care givers. One factor is that that a large majority of youths coming to the Center are already smokers and they wish to continue. By signing this consent you are granting continued permission to your child to smoke while they are in treatment at the Walgwan Center. In addition you are agreeing to provide him or her with tobacco for the duration of their stay.

In signing this consent you agree to provide your child with the cigarettes needed for the duration of their stay. The youth should arrive with cigarettes sufficient for their program in its entirety (14 week program = 2 cartons of cigarettes, 4 week prevention = 5 packs of cigarettes). Cigarettes WILL NOT be purchased for your child while at the Center.

Please sign in the space below to consent:

As care giver, I give my consent to allow the youth to smoke:

Parent or Guardian _____ Youth _____

Date _____

If this form is not returned, we will assume that this youth does not have permission to smoke.

Note that the Walgwan Center staff has the right to revoke all smoking privileges in the case of infraction to the rules by the youth.

I am willing to follow the above rules

Youth's signature _____

Date : _____

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 : _____