Centre Walgwan Center

Check List before sending

A) Please complete the following material

Admission Request Form	☐	Consent to Nicotine Patches	☐
Consent to Care Form	☐	Commitment to Care Form	☐
Activity Consent Form	☐	Consent to disclose and obtain information	☐
Consent to Immunization	☐	Consent to Video Monitoring	☐
Procedures for AWOL	☐	Other Clinical Reports if available	☐

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

	Is included	Will follow	Is not available
Birth certificate	☐	☐	☐
Social Insurance Card	☐	☐	☐
Scholastic info & School Report	☐	☐	☐
Info on consumption of substances	☐	☐	☐
Court Order/Alternative Measures	☐	☐	☐
Consent Form	☐	☐	☐
Medical Report	☐	☐	☐
Health Care Card	☐	☐	☐
Family information	☐	☐	☐
Others (reports from previous treatment)	☐	☐	☐
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 1Y0
Telephone: 418 759-3006
Fax: 418 759-3064
ashley@walgwan.com

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.
			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	Choose an item.	Is he/she sexually	Choose an item.

girlfriend?		active?	
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.
Name of Clinic			
Name of Medical Examiner		Title	
Postal Code		Phone	
BP		Client's weight	Client's height
Are immunizations up to date?	Choose an item.		
If not, what is presently required?			
A test for Tuberculosis is required prior to admission	Date of test	Click or tap to enter a date.	
Results:			
Is test report included?	Choose an item.	If not, please explain	
If appropriate indicate Date of last menstrual period?	Click or tap to enter a date.		
Is client pregnant?	Choose an item.	If yes, how many weeks?	
Physical examination by:		Date of exam:	Click or tap to enter a date.

		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	☐
						(Disabilities)	☐
Asthma	☐	Diabetes	☐	Epilepsy	☐		☐

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 provide details of health problems and related treatments, if appropriate:

Legal Problems

Has your client ever been in trouble with the law?	Choose an item.
Please explain	

Current legal status:	**NO legal status**	☐	Or please provide all details required below as applicable

Youth Protection Act	☐			**Young Offenders' Act**	☐		
Article 38,	Choose an item.			Alternative Measures	☐	Court Order	☐
				Ordinance #		Article #	
Alternative Measures	☐	Court Order	☐	Description			
Ordinance #		Article #					
Expiration Date:	Cliquez ici pour entrer une date.			Expiration Date:	Cliquez ici pour entrer une date.		
				Offence:			

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

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

Date and duration of placement	Residence	Caregiver's Name

Court Appearance: Is there a date where the client must appear in court?	Choose an item.
If yes, please provide date of appearance.	
Reasons:	
Is there anyone who is forbidden from contacting this client? (court injunction, limitations)	Choose an item.

Name:		Relationship to the client	

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

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	Click or tap to enter a date.	
Conditions					
Copy attached?	Choose an item.	Has your client been involved with any substances abuse?		Choose an item.	

Chemical Use History

Solvent and other Substance abuse information

Please indicate all known substances used by the client:

Gasoline	☐	Butane	☐	Cleaning fluids	☐	Diesel fuel	☐
Nail polish	☐	Cement	☐	Paint remover	☐	Typewriter correction fluid	☐
Hair spray	☐	Propane	☐	Deodorants	☐	Nail polish remover	☐
Spray paint	☐	PCP	☐	Glue	☐	Room deodorizer	☐
Alcohol	☐	Cocaine	☐	LSD	☐	Marijuana, weed or hashish	☐
Prescribed medication	☐			Over counter drugs	☐		

Specify which ones		Which ones? (Tylenol, cough syrup)	
Others? Please specify			

List substances used in order of preference

Substance	Date		Frequency of use	Quantity consumed
	First Use	Last Use		

Did the client's usage of substances increase over time?	Choose an item.
At what age did the client used the most?	
What elements trigger use of substances?	

What are the reasons given by the client for using substances?

To make friends	☐	To do like 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	☐				

Has the client ever experiences a period of abstinence?	Choose an item.
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?

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

Loss of friends	☐	Suspension from school	☐	Aggressive behaviour	☐
Feelings of regret	☐	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	☐	Become 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	

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	Choose an item.	Does your client usually sniff or	Choose an item.

at a party?		huff outdoor?	
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?			
Mental Health Problems			
Does client have mental health problems?	Choose an item.		
If yes, please specify	Choose an item.		
Others, please specify			
Please provide information concerning the client's mental problems, such as what triggered them, the date 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?	Choose an item.
If yes, Name of specialist	
Reasons for follow-up:	
Please, provide the report of the specialist – Is report included?	Choose an item.
If the client is not under care, would you suggest a professional follow-up based on you evaluation?	
Choose an item.	If yes, for what reasons?
Does the client take medication?	Choose an item.
If yes, please list:	

Medication	Start Date/End Date	Dosage	Reason

Does client have any dietary restrictions?	Choose an item.
If yes, please list:	
Please provide all other relevant medical information:	
Date client was seen:	Click or tap to enter a date.
Signature of specialist:	
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)

Centre Walgwan Center * 75 School Street * Gesgapegiag * QC * G0C 1Y1
Phone: 418 759-3006 * Fax: 418 759-3064 * www.walgwan.com

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 Information[1]

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

ACTIVITY CONSENT FORM

AND APPROVAL BY PARENTS OR LEGAL GUARDIAN

The recommended use of this form is for the consent and approval for Centre Walgwan Center, and guests to participate in a trip, or activity.

First Name _____ Middle Name _____ Last Name _____

Birth date _____ Age during activity _____

Address _____ City _____

Province _____ Postal code _____

Has my approval to participate in (name of activity, outing trip, etc.)

Name of activity _____

From (date) _____ To (date) _____

INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

I understand that participation in Centre Walgwan Center activities may involve the risk of personal injury.

I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving my child, I understand that efforts will be made to contact me. In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

With appreciation of the risks associated with programs and activities including preparations for and transportation to and from the activity, on my own behalf and/or on behalf of my child, I

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.

_____ Date: _____
(Parent/Guardian's Signature)

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	
Hair color:	
Eye color:	
Height:	
Weight:	

Insert Client's Picture

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 _____