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

Questions in **RED** on this form are mandatory.
PLEASE NOTE THAT ALL SECTIONS MUST BE FILLED. NON-COMPLETE APPLICATIONS MAY BE RETURNED, THUS DELAYING THE ADMISSION PROCESS. The form must be completed by the referral agent. Do not hesitate to attach additional sheets if necessary. After saving this document, please send it to ashley@walgwan.com

Table of Contents

CENTRE WALGWAN CENTER

ADMISSION REQUEST

Client information

Date application received by Community Worker _____

Date Application received by Treatment Center _____

Surname _____ First Name _____

Nickname _____ Date of Birth _____

Age _____ Sex _____ Provincial Health Card _____

Client's Address _____

_____

_____

Client's Phone _____

Spoken Language _____ Preferred Language _____ Language Understood _____

Indian Status _____ Treaty # _____ Band Name _____

Biological Parents _____

Legal Guardian Name _____

Guardian Address _____

_____

_____

Guardian Phone _____

Place of Employment _____ Phone _____

Emergency Contact _____

Social Services Involvement

Agency Name _____ Phone _____

Worker Name _____

Client Status	Crown Ward	☐	Society Ward	☐
	Voluntary Placement	☐	Customary Care	☐
		☐	Other _____	

Family Relationship

Does client have dependent children?	Yes		No	
If yes, do they have access to adequate childcare while in treatment?	Yes		No	
Are these children in care?	Yes		No	
Does client have other dependants?	Yes		No	

Provide information on client's children or other dependants

Name	Age	Relationship

Who does client live with?			
Mom only		Dad only	
Mom and Dad		Alone	
Friends		Siblings	
Foster Care		Extended Family Member	

Who client is closes to? _____

How does client get along with his/her family members? _____

Does client have any siblings? _____

Name	Age	Health Status	Lives with…

Mother's Name _____

Father's Name _____

Does client have any close friends? _____ If so, who? _____

Does she/he have a boyfriend/girlfriend? _____ Is he/she sexually active? _____

Does client talk to the elders? _____ Is client willing to listen? _____

Religious Beliefs _____

Other _____

Family Supports _____

Family Strengths _____

Education

Does client go to school? _____ Does client like school? _____

Highest grade completed _____

Does client have and Individual Education Plan? _____ If so, please attach

Name of School _____

Last year attending school _____

Legal Problems

Has client ever been in trouble with the law? _____

Please, explain _____

_____

Current legal status **NO legal status** ☐

Or please provide all details required below as applicable

Youth Protection Act ☐

Article 38 (write A, B, C, D, E, F or G)			
Alternative Measures		Court Order	
Ordinance #		Article #	
Expiration Date			

Young Offender's Act ☐

Alternative Measures ☐ Court Order ☐

Ordinance #		Article #	
Expiration 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

Time and Duration of Placement	Residence	Caregiver's Name

Must client appear in court? _____ If so, please indicate the date _____

Reasons _____

_____

Is there anyone who is forbidden from contacting this client (court injunction, limitations)?

Name		Relationship to client	

Please attach pre-sentence documents, court decisions, probation or any other relevant document.

Was alcohol or any other substances: such as sniff or drugs involved during your client's legal problems? _____

Please explain: _____

Is client currently on probation or on a court order? _____

Name of Probation Officer _____

Phone _____ Fax _____

Probation Order From (date) _____ To (date) _____

Conditions _____

Copy attached ☐ Has your client been involved with any substances abuse? _____

Chemical History Use

Solvent and other Substance abuse Information

Please indicate all known substances used by client

Gasoline	☐	Butane	☐	Cleaning fluids	☐	Diesel fuel	☐
Nail Polish	☐	Cement	☐	Hair Spray	☐	Paint remover	☐
Propane	☐	Deodorants	☐	Typewriter correction fluid	☐	Nail polish remover	☐
Glue	☐			Room deodorize	☐	Spray Paint	☐

Prescribed Medication	☐	Over counter drugs	☐
Specify which ones		Which ones? (Tylenol, cough syrup)	

Alcohol ☐ Marijuana, *Weed* or Hashish ☐ Cocaine ☐ PCP ☐ LSD ☐

Other, specify:

List substances used in order of preference

Substance	Date		Frequency of use	Quantity consumed
	Frist Use	Last use		

Did the client's usage of substances increase over time? _____

At what age did the client use the most? _____

What elements trigger use of substances?

_____

_____

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

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

Has the client ever experienced a period of abstinence? _____

If so, 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	☐	Experienced a blackout	☐	Forgetting what happened	☐
Feelings of guilt	☐	Experienced suicidal attempt	☐	Being afraid without knowing why	☐
Having to be taken to the hospital	☐	Become sick after stopping to sniff for a couple of days			☐
Experienced hallucinations	☐	Havin been in dangerous situations or in an accident			☐
Hurt somebody you care about	☐				

Comments: _____

At what age did the client start sniffing? _____

At what age did the client start drinking alcohol? _____

At what age did the client start using other drugs? _____

Does anyone else in the family use solvent/substances? _____

If so, who else? _____

Does client use solvent/substances with others or by him/herself? _____

Does client usually sniff or huff at home? _____

Does client usually sniff or huff at a friend's house? _____

Does client usually sniff or huff at school? _____

Does client usually sniff or huff in an abandoned building? _____

Does client usually sniff or huff in an abandoned car or truck? _____

Does client usually sniff or huff at a party? _____

Does client usually sniff or huff outdoor? _____

Is there any other place your client usually sniffs or huffs? _____

Has your client ever lost friends because of sniffing or huffing? _____

Has your client ever gotten into any physical fights when using? _____

Has your client ever caused serious injuries to other? _____

Please explain: _____

Does he/she feel that they have control over their use of solvents/substances _____

Has he/she ever considered reducing or quitting? _____

Has he/she ever been in any previous treatment for their use of solvents/substances? _____

If so, where have had previous treatment? _____

When have they had previous treatment? _____

How long did the client stay in the program? (In months) _____

Has the client participated in a non-residential/community-based substance abuse and/or mental health program? _____

If yes, what type of program? _____

Psychological Functioning

Has your client ever spoken or written about killing him/her self? _____

Has your client ever attempted to kill him/her self?

How many times? _____

How did he or she attempt to kill him/her self? _____

Has the client frequently gone off on their own when depressed or unhappy? _____

Is the client sad or unhappy? _____

How often is the client sad or unhappy? _____

Is there any known history of sexual abuse? _____

Is there any known history of physical abuse? _____

Il there any known history of emotional abuse? _____

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? _____

Please explain: _____

When the client is in a sober state has he/she communicated with spirits that no one else can see or hear? ____

Are these communications positive or negative experiences for the client? _____

Explain: _____

Are there times when people are unable to communicate with the client? _____

Explain: _____

Has your client ever had any psychological testing or counseling? _____

If so, for what purpose? _____

Outside Resources

Are there any other agencies involved with your client and his/her family? _____

If so, which ones and what services do they provide? (for example, NNADAP, 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's family aware of the effects of solvents/substances? _____

Is the client's family aware of the effects of solvents/substances? _____

Is the client's community worker aware of the effects of solvents/substances? _____

What steps does the family want to take to address the problem?

_____

Has anyone in his/her family received treatment for solvents/substances abuse? _____

Please, explain: _____

Are the parents supportive of their child receiving treatment? (Refer to Referral Agent Agreement and Parental Consent Form) _____

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? _____

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? _____

Medical Information

CLIENT'S MEDICAL INFORMATION

This section should be filled by doctor or a nurse

Identification of physician (or nurse):

Name of Clinic: _____

Name of Medical Examiner: _____ Title: _____

Postal Code: _____ Telephone: _____

Client's information:

Name: _____

Client's file number: _____ Health Insurance #: _____

BP: _____ Weight: _____ Height: _____

Are immunizations up to date? Yes ☐ No ☐ Unknown ☐

If not, what is presently required? _____

If appropriate indicate: Date of the last menstrual period: _____

Is client pregnant? Yes ☐ Non ☐ If yes, how many weeks? _____

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	☐ Coordination problems
☐ Allergies	☐ STD	☐ Hyperactivity	☐ Mental deficit
☐ Agitation	☐ Difficulty in concentrating	☐ Hallucinations	☐ Vision problems
☐ Hearing problems	☐ Poor memory	☐ Skin problems	☐ Poor hygiene
☐ Lice and nits			

Please note that if the client is currently on prescribed medication, he must arrive at the Center with the written prescription. We will then make sure to submit the prescription to the pharmacy to get her medications.

Donnez des détails sur les problèmes et traitements, si nécessaire :

Mental Health

Does client have mental health problems? Yes ☐ No ☐ Unknown ☐

If yes, please specify? ☐ Fears, distress ☐ Depression ☐ Suicidal Ideations ☐ Suicidal Attempts ☐ Paranoia ☐ Others:

Please provide information concerning the client's mental health 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 bases on your evaluation?

Yes ☐ No ☐ If yes, for what reasons? _____

Medication

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

Medication	Start Date/End Date	Dosage	Reason

Dietary Restrictions:

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

Please provide all other relevant medical information:

Date the client was seen: _____

Signature of the specialist: _____

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 Nicotine Replacement Therapy

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 replacement therapy (patches, gum or lozenges) 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 get and use nicotine replacement therapy:

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 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 _____