CENTRE WANAKI CENTRE
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ADMISSION REQUEST
FOUR WEEK RESIDENTIAL PROGRAM

Updated February 2024

This admission form contains five (5) sections:

Section 1: Informed Consent
Section 2: Client Admission/General Information
Section 3: To be completed by the client
Section 4: Health Evaluation
Section 5: Transportation

- □ **STEP 1:** The Wanaki Centre must receive sections 1 to 6 fully completed before we can proceed with our clinical assessment. We highly recommend to all applicants to have a referral worker for support.

- □ **STEP 2:** The Centre will complete a clinical assessment. The Centre's admission decision will be provided to the referral and client.

- □ **STEP 3:** Upon receipt of the admission decision, the referral and client must sign and return the signed form by fax or email to confirm the client's admission to the residential program cycle.

- □ **STEP 4:** Once the Wanaki Centre has received the signed admission decision form by the client and referral worker, a Zoom or phone pre-contact meeting will be scheduled with the client prior to the start of the program to provide additional information.

There are 5 principles to follow:

- No possession or consumption of alcohol or drugs during the treatment
- No violence of any kind
- To adhere to the structure rules and regulations from the beginning to the end of the cycle
- No intimate contact
- No smoking in the main building or outdoor structures

All applications sent to the Wanaki Centre can or will be deferred from a program only once. If an application exceeds a period of 3 months, a new application will have to be re-submitted.

You are responsible to work to the best of your ability on your 4 aspects:

- Physical (walking, exercise)
- Mental (paying attention during workshops, reading, learning from others)
- Spiritual (smudging, praying, meditation, offering tobacco)
- Emotional (writing in my journal, sharing in the circle)

SECTION 1: INFORMED CONSENT

Informed Consent Form

Wanaki is a recognized NNADAP Treatment Centre with years of experience specializing in various counseling fields. We value our relationship with our clients and believe that such relationship is the guide in the healing process.

We believe that everyone is unique and has their own way of addressing resolutions. Thus, we believe in a wellness model that helps our clients empower themselves by focusing on what works for them and not in a systematic approach that provides a generic procedure on working on a treatment. One's journey is not the same as the other.

Client's Rights

1. The client may ask questions on what to expect during the treatment program.
2. The client may cease the treatment program at any time.
3. The Clinical Team has the right to dismiss the client from the treatment program.
4. Right to confidentiality: Within limits provided for by law, all records and information acquired by the counsellor will be kept confidential in accordance with the principles of a counsellor/client relationship. All information will not be shared or revealed to any person, agency, or organization without the prior written consent of the client.
5. The client can raise any concerns and speak with a counsellor provided that the counsellor is likewise available to discuss matters with the client.

Emergency Contact Consent

For safety measures we require that you provide 2 (two) emergency contacts. Your consent is required for Wanaki centre in case of emergency.

Emergency Contact #1	Emergency Contact #2
Name:	Name:
Phone number:	Phone number:
Relationship:	Relationship:

I _____, declare that I have read all the information including my responsibilities. I understand that if I do not abide by the outlined principles and responsibilities that I could be asked to leave the program. I agree that if I am accepted in the program that I will fully participate on a daily basis, and complete work assignments.

_____ _____

Client Signature Date (D/M/Y)

_____ _____

Referral Signature Date (D/M/Y)

SECTION 2: CLIENT ADMISSION – GENERAL INFORMATION

**** Please include a copy of provincial health and the first nation status card or Inuit registration**

*Surname:	*Name:			
Email:			Health card number & exp. date:	
*Date of birth DD/MM/YYYY:	Age:	*Sex (identify as):	Telephone:	Cellphone:
*Address (Add P.O box if required)			City:	Province: / Postal Code:
Language Spoken:	Language Preferred:		Language Understood:	
Community:	Nation:		First Nation status number / Inuit registration:	

EDUCATION

Last grade completed? _____	Where?	Reading Level:	Writing Level:
☐ Elementary school ☐ High School ☐ College ☐ University ☐ Professional ☐ Other:	☐ Public Off-Reserve ☐ Public On-Reserve ☐ Private School ☐ Residential School	☐ Excellent ☐ Good ☐ Poor	☐ Excellent ☐ Good ☐ Poor

FINANCIAL SITUATION

Employment status / Financial situation:	What has been your principal source of income during the past six months?
	☐ Work ☐ Spouse ☐ Parents ☐ Social Assistance ☐ Employment Insurance ☐ Pension or Insurance ☐ Other (please specify) _____

FAMILY / RELATIONSHIPS

Marial Status:	Does client have dependent children?	If yes, do they have access to adequate childcare while in the program?	Are the children in care?	Does the client have other dependents?
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	☐ Yes ☐ No If yes, how many? _____	☐ Yes ☐ No ☐ Not applicable	☐ Yes ☐ No ☐ Not applicable	☐ Yes ☐ No

Provide information on the client's children or other dependents:

Name	Age	Relationship

Family Support:	Family Strengths:

****PLEASE READ CAREFULLY****

If you have any legal situations, you will have to meet the following criteria.

Provide any supporting documentation requested by Wanaki to complete a proper assessment of the application. Referral workers will need to provide Wanaki with a written confirmation from the court that the client will not have any court appearances, probationary conditions or parole conditions that would interrupt the client's treatment services for 4 weeks. If the person applying has an active criminal record, a copy of this record will need to be forwarded to us to complete the application.

The detention centre or community will have to ensure that the client arrives at Wanaki Center with the transportation and means to return home or to the detention center where they are from.

NOTE: If a client arrives with legal conditions on intake day without return transportation means they will not be accepted.

LEGAL STATUS

Has the client been court ordered to attend the program?

- ☐ Yes
- ☐ No

If yes, provide details (include details/copy of Probation Order if applicable and/or available)

Is the client under any of the following legal condition?

- ☐ Bail
- ☐ Parole
- ☐ Temporary Absence Order

Legal System Involvement:

- ☐ Criminal Court
- ☐ Family Court
- ☐ Drug Court Treatment
- ☐ Probation
- ☐ Charges Pending
- ☐ Court Order
- ☐ Restorative Justice
- ☐ Pre-trial Release
- ☐ Conditional Sentence

Other (provide details, dates, etc.): ***MANDATORY** to provide criminal records information

HISTORY

Has client participated in a non-residential / community-based substance abuse program?

- ☐ Yes
- ☐ No

Has the client participated in a non-residential / community-based mental health program?

- ☐ Yes
- ☐ No

Has the client participated in a residential / virtual treatment program before?

- ☐ Yes
- ☐ No

If yes, how many? _____

If yes, please provide information on previous treatment experience:

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Reason(s) for currently requesting to join a program?

CONSUMPTION

What age were you when you first started consuming substances?		What age were you when you first started began having serious substance abuse issues?	

On average how often do you consume substances?

☐ Everyday ☐ Weekends ☐ Few days a week ☐ 1-2 days a month

What type(s) of substance do you abuse?

Alcohol:

- ☐ Beer
- ☐ Liquor
- ☐ Wine
- ☐ Other: _____

Drugs:

- ☐ Weed
- ☐ Cocaine
- ☐ Speed
- ☐ Ecstasy
- ☐ Crystal Meth
- ☐ Opioids
- ☐ Heroin
- ☐ P.C.P
- ☐ Acid
- ☐ Mescaline
- ☐ Solvent/Inhalants
- ☐ Other: _____

Abuse Prescription drugs:

- ☐ Yes
- ☐ No

If yes, specify:

Nicotine:

- ☐ Cigarettes
- ☐ Vapes
- ☐ Cigars
- ☐ Shewing tobacco
- ☐ Pipe
- ☐ Other: _____

Sober since (if applicable):

Why do you think you use substances?

WITHDRAWAL SYMPTOMS		
Has client experienced any of the following symptoms while withdrawing from substances in the last 12 months?		
Symptom		Describe
Blackouts	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Hallucinations	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Nausea/Vomiting	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Seizures	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Shakes	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Delirium Tremens (DT's)	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Ever experienced DT's?	☐ Yes ☐ No	
PROCESS BEHAVIOURAL ADDICTION		
Has client experienced problems with any of the following in the past 12 months?		
Process/Behavioural Addiction		Describe
Gambling (slots, cards, Keno, bingo, etc.)	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Sex (promiscuity, etc.)	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Cellphone/texting	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Social media	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Gaming	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Other (please specify):	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	

MENTAL HEALTH		
Provide the following information about the client's health status in the past 12 months:		
Mental Illness		Describe
Been diagnosed with a mental illness	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	If yes, please explain:
Currently being treated	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Currently on psychiatric medication	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	If yes, please list medication:
Taking medication consistently	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
*Previous suicide attempts/ideation	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	If yes, when?
*Hospitalized for suicide attempts	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	If yes, when?
*Currently suicidal	☐ Yes ☐ No ☐ Not applicable ☐ Unknown	
Other important information:		Name and phone number of psychiatrist/psychologist (if applicable)

OTHER		
What spiritual/religious beliefs do you follow?		Are you interested in learning basic Algonquin First Nation Cultural and Spiritual teachings? (Please take note, this is part of the program) ☐ Yes ☐ No
Does the client have cultural and/or spiritual beliefs and practices we need to be aware of?	☐ Yes ☐ No	If yes, please describe:
Does client have literacy or learning needs or issues we need to be aware of?	☐ Yes ☐ No	If yes, please describe:
Are there any other significant issues we need to be aware of?	☐ Yes ☐ No	If yes, please describe:
Does client understand there is an expectation they have been alcohol and drug free for at least 7 days prior to admission (or 14 days if withdrawing from benzodiazepines). (Client with less than the required days must notify Wanaki Centre prior to admission).		☐ Yes ☐ No
Personal strengths:		

REFERRAL INFORMATION				
Surname:		Name:		
Employment title:	Telephone:		Cellphone:	
Organization:		Email:		
Organisation address:(Add P.O box if required)		City:	Province:	Postal Code:
Has the client completed two pre-program appointments? ☐ Yes ☐ No		Will you continue to see the client once he/she has completed the program? ☐ Yes ☐ No		

Please provide appointment dates	Date 1:	Date 2:	Date 3:	Date:

What other supports would be available to your client in their community upon completion of treatment?

Name/Resource	Description of support

Please provide/attach a brief assessment summary (Assessment Summaries completed within 6 weeks of this application may be substituted and attached) including summarization of any assessment processes completed with the client (e.g., SASSI, MAST, DAST, etc.) which support the application to the program and evaluate how addictions have affected your client in all domains (e.g., domestic, medical, school, psychological, spiritual, emotional).

CLIENT'S STAGE OF READINESS

- ☐ Precontemplation - Not considering change; resistant to change.
- ☐ Contemplation - Unsure of whether or not to change, chronic indecision.
- ☐ Determination - Preparation; committed to changing behaviour within one month.
- ☐ Action - Begin changing behaviour.
- ☐ Maintenance - Behaviour change has persisted for 6 months or more.

Please list any questions or concerns the client has indicated during the intake process:

What other areas might need to be addressed in the program? (e.g., abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):

Referral assessment of the client's strengths and potential challenges for completing the program:

REFERRAL CHECKLIST		
Please initial which applicable items have been completed. Check off any items attached to this application:		
Item	Attached	Initials
Psychiatric Evaluations	☐ Yes ☐ No	
Probation Order	☐ Yes ☐ No	
Current Medical Assessment Evaluation	☐ Yes ☐ No	
Assessment Summary	☐ Yes ☐ No	
Substance Abuse Profile	☐ Yes ☐ No	

Please Initial each item that has been completed:	
Item	Initials
All medical, dental, and optical appointments have been dealt with prior treatment.	
All financial matters have been dealt with prior treatment.	
All legal matters have been dealt with prior treatment.	

REFERRAL ASSESSMENT		
Do you think your client needs detox before starting our residential program?	☐ Yes ☐ No	If yes, please explain more:

SIGNATURE	
Referral Signature	**Date (D/M/Y)**

SECTION 3: TO BE CLOMPLETED BY THE CLIENT

MOTIVATION
Are you willing to work in a residential group structure? (Sharing in group, presentations, etc.)
Do you have difficulties following the rules and regulations?
EXPECTATION
Sometimes people have mixed/confused feelings about following a healing program, how do you feel?
In which areas do you see us helping you (i.e., emotional, mental, physical, spiritual)?
What expectation do you have for yourself (i.e., commitment, learning)?
MOTIVATION LETTER
Please tell us in your words why you are motivated to participate in the Wanaki Centre's residential program

CLIENT AUTORISATION

I authorize the information submitted in this application to be added to the Addiction Information Management System. I understand and agree to accept the treatment program as described by the Wanaki Centre.

Client Signature	**Date (D/M/Y)**
Referral Signature	**Date (D/M/Y)**

SECTION 4: MEDICAL EVALUATION

PHYSICIAN/NURSE INFORMATION			
Surname:	Name:		
Employment title:	Telephone:	Cellphone:	
Organization:	Email:		
Organisation address:(Add P.O box if required)	City:	Province:	Postal Code:
Client's surname:	Client's name:		

DOES THE PERSON HAVE THE FOLLOWING CONDITIONS, AS DIAGNOSED BY A PHYSICIAN? CHECK OFF ALL THAT APPLY			
☐ Pregnancy ***Please take note that the Wanaki Centre does not accept women passed 20 weeks within the resident***	Number of weeks?	Are you followed by a doctor? ☐ Yes ☐ No	Date of last medical exam?
	Other comments (e.g., date of next medical appointment, number of previous pregnancies, voluntary termination of pregnancy, high risk pregnancy etc.):		
☐ Cardiac Disorders (including hypertension, low blood pressure, angina)	Date of last episode?	Please specify which cardiac disorder:	Last medical exam?
	Are you followed by a doctor? ☐ Yes ☐ No	Are you awaiting surgery? ☐ Yes ☐ No	
	Other comments (ex; date of next appointment, family history, etc.)		
☐ Epilepsy	Date of last episode?	Last medical exam?	Are you followed by a doctor? ☐ Yes ☐ No
	Other comments (ex; date of next appointment, etc.):		

☐ Hepatic Disorder (e.g.: Cirrhosis, jaundice, hepatitis A,B,C, liver problem, edema)	Date of last episode?	Please specify which hepatic disorder:	Last medical exam?	Are you followed by a doctor? ☐ Yes ☐ No
	Other comments (ex. date of next appointment etc.)			

☐ Diabetes	Last medical exam?	Are you followed by a doctor? ☐ Yes ☐ No	Is your diabetes stable? ☐ Yes ☐ No
	Are you taking insulin? ☐ Yes ☐ No	Do you follow a special diet? ☐ Yes ☐ No	Date of your last blood test (A1C result)?
	Other comments (ex. date of next appointment etc.)		
☐ Recent history (1 month) of head trauma with loss of consciousness (ex: fractured skull)	Date of event?	Last medical exam?	Are you followed by a doctor? ☐ Yes ☐ No
	Other comments (ex: date of next appointment, etc):		
☐ Respiratory disorders (Asthma, chronic bronchitis, emphysema, infections, cough)	Please specify which respiratory disorder:	Do you have a cough? ☐ Yes ☐ No If yes, characteristics of expectoration?	
	Date of last episode?	Last medical exam?	Are you followed by a doctor? ☐ Yes ☐ No
	Other comments (ex: date of next appointment, specialists, etc):		
☐ Allergy (drugs, food, others)	Please specify allergies.	Types of reactions? (rash, hives, anaphylactic etc)	
	Are you followed by a doctor? ☐ Yes ☐ No	Do you take any medications? ☐ Yes ☐ No	EpiPen? ☐ Yes ☐ No
	Other comments (ex: date of next appointment, specialists, etc):		
☐ Mental health disorders (anxiety, depression, psychosis, schizophrenia etc)	Please specify:		
☐ Other (Ex: STBBI, HIV, Inflammations, infections, condition of injection sites and all other wounds, mobility problems, unstable/undiagnosed issues, significant weight gain/loss)	Please specify:	Last medical exam?	Are you followed by a doctor? ☐ Yes ☐ No
	Other comments (ex: date of next appointment)		

PHYSICAL EXAM

Blood pressure:	Heart rate:	Respiration:	Temperature:
Weight:	Height:	Blood Glucose:	Wounds:

Do you suggest any additional medical exam, tests, or investigations prior to the client's admission to the Wanaki?	☐ Yes ☐ No	If yes, please specify:	
In your opinion, does your client require substance abuse detoxification prior to entering the Wanaki residential program?	☐ Yes ☐ No	If yes, please explain:	
Do you have a family doctor or Nurse on a regular basis?	☐ Yes ☐ No	If yes, first and last name of medical professional:	
		Clinic Name:	
		Phone Number:	City:

WANAKI TUBERCULOSIS SYMPTOM SCREENING QUESTIONNAIRE		
Part A should be answered by the applicant. A healthcare professional must evaluate the answers and assign a recommendation in Part B. Please note that a **TB skin test is not mandatory** for entry to the Wanaki Centre. If the client answers YES to more than one question, we recommend further investigation prior to admission to the Wanaki Centre.		
PART A		
A productive cough for more than 3 weeks?	☐ Yes	☐ No
Hemoptysis (coughing up blood)?	☐ Yes	☐ No
Unexplained weight loss?	☐ Yes	☐ No
Fever, Chills, or night sweats for no known reason?	☐ Yes	☐ No
Persistent shortness of breath?	☐ Yes	☐ No
Unexplained fatigue?	☐ Yes	☐ No
Chest Pain?	☐ Yes	☐ No
Have you had contact with anyone with active tuberculosis in the past year?	☐ Yes	☐ No
Does your community currently have tuberculosis cases?	☐ Yes	☐ No
Had a TB skin test?	☐ Yes	☐ No

If yes to a TB test	Date:	Result:

PART B
Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:
☐ There is no indication this person has active tuberculosis at this time.
☐ Further evaluation, including a TB Skin Test or other medical evaluation is indicated, and should be completed prior to admission to a facility.

Health Professional signature	Printed name	Date

MEDICATION		
****PLEASE READ CAREFULLY**** We prefer a pharmacy printout of the participants' medication record. We also ask that the client arrives at the centre with 4 weeks of their medication already prepared in DOSETTES (blister packaging from pharmacy) if not available, we ask that they show up with no more than 3 days' worth of medication. Do not bring any medications not prescribed; it will be disposed of. Same thing with powder protein supplements. We optimize healthy eating which provides all the nutrients the body needs.		
Is your client taking any prescribed medication currently? (If yes, please specify name, dosage, duration, and any special recommendations for use or attach pharmacy list)		
Name of medication	Reason	Psychoactive effect

I have examined _____ and find him/her fit to attend the Wanaki Center's residential treatment facility.

Physician or Nurse's Verification Stamp

_____ _____

Physician or Registered Nurse's Signature Date DD/MM/YYYY

SECTION 5: TRANSPORTATION

TRAVEL INFORMATION

The applicant will be travelling to the Wanaki Center using the following methods of transportation:

☐ Bus ☐ Plane
☐ Train ☐ Personal Vehicle
☐ Taxi/Medical transportation ☐ Family

Will more than one method of transportation and/or require staying overnight halfway through the trip? ☐ Yes ☐ No
If yes, please provide further details: (i.e., contact person, phone number, hotel name, etc.)

Which transportation method will be used to return home after the completion of the program?

☐ Bus ☐ Plane
☐ Train ☐ Personal Vehicle
☐ Taxi/Medical transportation ☐ Family

When will the applicant be leaving the community?

Date: _____ Time: _____

If the applicant arrives by bus, please provide details of destination (Grand-Remous or Maniwaki)

Town: _____ Date: _____ Time: _____

TRANSPORT COORDINATOR

Surname:	Name:	
Employment title:	Telephone and/or Cellphone:	Fax:
Organization:	Email:	

Will travel costs be provided by the community or organization if the applicant does not complete the program?
☐Yes
☐No
Comments or conditions:

This form is to be completed by the person responsible for the return travel costs for the Applicant. The Wanaki Center does not pay for travel costs.

I, _____(Applicant's Name) agree to pay for all incurred travel costs if I am discharged or leave voluntarily.

_____ _____
Signature of transportation coordinator/Other Date DD/MM/YYYY