CENTRE WANAKI CENTRE

50 Wanaki Mikan   P.O. Box 37, Maniwaki (Qc) J9E 3B3   ADMISSIONS: ext 4227
819-449-7000   1-800-745-4205   819-449-7832   819-449-2007
reception@wanakicentre.com   www.wanakicenter.com   admissions@wanakicentre.com

WELLNESS WEEK APPLICATION
VIRTUAL PROGRAM

This admission form contains four (4) sections:

Section 1: Informed Consent
Section 2: Client admission – General Information
Section 3: To be completed by the client
Section 4: Health Evaluation

☐ **STEP 1:** The Wanaki Centre must receive sections 1 to 4 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 within 7 working days. The Centre's admission decision will be provided to the referral and client in writing.

☐ **STEP 3:** Upon receipt of the admission decision, the refferal and client must sign and return the signed form by fax or email within 7 days to confirm the client' admission to the virtual program cycle.

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

There are 4 principles to follow:

- Respect for yourself and others
- Honesty with yourself and others
- Willingness to listen and learn
- Openess to share

All applications sent to the Wanaki Centre are valid for 3 months. If an application exceeds 3 months, a new application application will have to be submitted.

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

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

SECTION 1: INFORMED CONSENT

Informed Consent Form

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

We believe that each individual is unique and has his 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 and end result of the program.
2. The client may decline to proceed the program as to the techniques which may be conducted by the clinical team.
3. The client may cease to continue the program anytime, without any impediment and may return to Wanaki anytime.
4. The Clinical Team has the right to dismiss the client from the course of program.
5. The client has the right to review his or her records from the counsellor.
6. Right to confidentiality: Within limits provided for by law, all records and information acquired by the counsellor shall be kept strictly confidential in accordance to 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.
7. The client can raise any concerns and to speak with the counsellor immediately of any concerns provided that the counsellor is likewise available to discuss matters with the client

I ______________________________ , declare that I have read all of the information including my responsibilites. 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 progam that I will fully participate on a daily basis, and complete work assignments.

______________________________	______________________________
Client Signature	Date
______________________________	______________________________
Referral Signature	Date

SECTION 2: CLIENT ADMISSION - GENERAL INFORMATION

<table>
<tr><td colspan="2">Date Application Received by Community Worker</td><td colspan="2">Date Application Received by Treatment Centre</td></tr>
<tr><td>Surname:</td><td>First Name:</td><td colspan="2">Email:</td></tr>
<tr><td>Date of Birth:</td><td>Age:</td><td>Sex (identify as):</td><td>Provincial Heath Card Number include copy:</td></tr>
<tr><td colspan="3">Address:</td><td>Telephone:</td></tr>
<tr><td>Language Spoken:</td><td>Language Preferred:</td><td colspan="2">Language Understood:</td></tr>
<tr><td colspan="2">Emergency Contact Name:</td><td>Telephone:</td><td>Relationship:</td></tr>
<tr><td>Status Indian include copy:</td><td>Treaty Number:</td><td colspan="2">Band Name:</td></tr>
<tr><td>Education:</td><td>Literacy Level:</td><td colspan="2">Employment Status:</td></tr>
<tr><td colspan="4">Family/Relationships</td></tr>
<tr><td colspan="4">Marital Status:</td></tr>
<tr><td colspan="2">Does Client have dependent children?</td><td colspan="2">☐ Yes
☐ No</td></tr>
<tr><td colspan="2">If yes, do they have access to adequate childcare while in treatment?</td><td>☐ Yes
☐ No
☐ Not Applicable</td><td></td></tr>
<tr><td colspan="2">Are the children in care?</td><td>☐ Yes
☐ No
☐ Not Applicable</td><td></td></tr>
<tr><td colspan="2">Does the client have other dependants?</td><td>☐ Yes
☐ No</td><td></td></tr>
<tr><td colspan="4">Provide information on client’s children or other dependants:</td></tr>
<tr><td colspan="2">Name</td><td>Age</td><td>Relationship</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="4">Family Supports:</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Family Strengths:</td></tr>
</table>

LEGAL STATUS

Has client been court ordered to attend treatment?	☐ Yes ☐ No
If yes, provide details (include details/copy of Probation Order if applicable and/or available):	
Legal System Involvement:	☐ Criminal Court ☐ Family Court ☐ Drug Court Treatment ☐ Probation ☐ Charges Pending ☐ Court Referral ☐ Court Order ☐ Restorative Justice
Is the client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temporary Absence Order
Other (provide details, dates, etc.):	

Treatment History

Has client participated in a non-residential/community-based substance abuse program?	☐ Yes ☐ No
Has client participated in a non-residential/community based mental health program?	☐ Yes ☐ No
Has client participated in a residential treatment program before?	☐ Yes ☐ No
If yes, please provide information on previous treatment experience:	

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

Reason(s) for currently requesting treatment:

WITHDRAWL 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 DTs?	☐ Yes ☐ No	

PROCESS BEHAVIORAL 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	
Internet/texting	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

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

OTHER	
Does client have cultural and/or spiritual beliefs and practices we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Are there any other significant issues we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Does client understand there is an expectation of completion of a minimum of two counselling sessions prior to applying to residential treatment?	☐ Yes ☐ No
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 thetreatment centre prior to admission).	☐ Yes ☐ No
Personal Strengths:	

CLIENT AUTORISATION	
I authorize the documentation of my information for this application process in the Addiction Information Management System. I understand and agree to accept the treatment program as described by the Wanaki Centre.	
Client Signature	**Date**
Referral Signature	**Date**

REFERRAL INFORMATION				
Has the client completed four pre-treatment appointments?				☐ Yes ☐ No
Please provide appointment dates:	Date 1:	Date 2:	Date 3:	Date 4:
Will you continue to see the client once he/she has completed treatment?				☐ Yes ☐ No

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 treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, school, psychological, spiritual, emotional).	

CLIENT'S STAGE OF READINESS

- ☐ Pre-contemplation - 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 behavior
- ☐ 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 treatment? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):
Referral Agent assessment of client's strengths and potential challenges for completing treatment:

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 Forum	☐ 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 to treatment	
All financial matters have been dealt with prior to treatment	
All legal matters have been dealt with prior to treatment	
Referral Signature	Date (D/M/Y)

SECTION 3: TO BE COMPLETED BY THE CLIENT

MOTIVATION

Are you willing to work in a virtual group structure?

____

Do you have difficulty following rules and regulations?

____

EXPECTATIONS

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, spiritual, and physical)?

____

What expectations do you have of yourself (i.e. commitment, learning)?

____

PLEASE TELL US IN YOUR WORDS WHY YOU ARE MOTIVATED TO PARTICIPATE IN THE WANAKI CENTRE'S VIRTUAL PROGRAM

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EDUCATION

Last grade completed? ____

Where? ☐ Public Off-Reserve ☐ Public On-Reserve ☐ Residential School

Any other educational or training courses? ______________________________________

Reading Level: ☐ Excellent ☐ Good ☐ Poor

Writing Level: ☐ Excellent ☐ Good ☐ Poor

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 per month ☐ Sober since:
What type(s) of substance do you abuse? **Alcohol:** ☐ Beer ☐ Liquor ☐ Wine Other:
☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Speed ☐ Ecstasy ☐ P.C.P. ☐ Acid ☐ Mescaline ☐ Crystal Meth ☐ Solvents/Inhalants ☐ **Other (please specify):**
Prescription Drugs: ☐ YES ☐ NO **Specify**:
Why do you use substances?

CULTURE AND SPIRITUALITY

What spiritual/religious beliefs do you follow? ___________________________________

Are you interested in learning generic Algonquin First Nation Cultural and Spiritual teachings? ☐ **YES** ☐ **NO**

FINANCIAL SITUATION

What has been your principal source of income during the past six months?

☐ Work ☐ Parents ☐ Employment Insurance
☐ Spouse ☐ Social Assistance ☐ Pension or Insurance

Other (please specify): ____

***** If additional space is needed, please use another sheet*****

SECTION 4: MEDICAL EVALUATION

Clients Surname:		Given Name:
Physician's/Nurse's Surname:		Given Name:
Tel.(ext):		Email:
Address:		
City:	Province:	Postal Code:

Does your client have any chronic medical conditions that we should know about during his/her treatment at the Wanaki?
☐ **YES** ☐ **NO** (If yes, please specify)
____

Is your client suffering from an unstable medical condition at this time? ☐ **YES** ☐ **NO** (If yes, please specify)
____

Is your client taking any prescribed medication at this time? (If yes, please specify name, dosage, duration and any special recommendations for use)

Name of Medication	Reason	Psychoactive Effect

Clients attending treatment should be as free as possible from any prescribed medication that may alter the behavior of your client. (e.g. concentration level, fatigue, appetite, mood, etc.)

Does your client require any regular medical follow-up? ☐ **YES** ☐ **NO** If yes, please explain:____________________

Has your client ever suffered from a psychiatric disease that we should know about during his/her stay at the Wanaki?
☐ **YES** ☐ **NO** If yes, please explain:____

Do you suggest any additional medical exams, tests or investigations prior to the client's admission to the Wanaki?
☐ **YES** ☐ **NO** ____

In your opinion, does your client require substance abuse detoxification prior to entering the Wanaki Virtual Program?
☐ **YES** ☐ **NO**

I have examined ____________________and find him/her fit to participate in the Wanaki Centre's virtual program

____________________________________ ________________________
Physician or Registered Nurse's Signature **Date**

Physician or Nurse's Verification Stamp