Residential Treatment Package

If you have any questions or need assistance filling out this application, please contact our Intake Worker at 807-229-3592 ext, 651.

Date:_____

Information provided by (check all that apply): ☐ Client ☐ Worker

Referral Source:

☐ Self
☐ External Agency ***If referred by an external agency please provide the following:***

Name of Worker: _____

Yes, you can contact my worker if you are unable to get a hold of me at my primary phone number.

☐ _____
Signature of Client

Worker Contact Information:

Demographic Information

Legal Name:	Preferred Name:	Pronouns:
Date of Birth (dd/mm/yyyy):	Full Home Address:	Mailing Address (if different from home address):
Telephone Number:	Cell/Alternate Number:	Email:

Do we have permission to contact you by telephone, cell phone, alternate telephone, and email? Check yes to all that apply:
☐ Telephone ☐ Cell phone/alternate number ☐ Email

Self-Identification:

☐First Nation
☐ Metis
☐ Inuit
☐ Non-Status
☐ Other

First Nation Band if applicable: _____

Status Card Number: _____

Health Card and Code: _____

Do you feel comfortable attending programming with another member of your community?
☐ Yes ☐ No

Do you have a family member or friend that is currently employed with Biidaaban Healing Lodge? Or have you been employed with Biidaaban Healing Lodge:
☐ Yes, I am an employee of Biidaaban Healing Lodge
☐ Yes, I have a family member or friend that is employed at Biidaaban Healing Lodge
☐ No

Education and Work History

Education:
☐ Elementary
☐ Secondary
☐ Post-Secondary

Income:
☐Employed
☐ Ontario Works
☐ ODSP
☐ Unemployed
☐ Other

Employer:

Family Composition

Relationship Status:
☐ Single ☐ Divorced ☐ In a relationship
☐ Married ☐ Separated ☐ N/A
☐ Common Law ☐ Widowed

Do you have children? ☐ Yes ☐ No
Are the children in your care: ☐ Yes ☐ No
If no, please explain:

_____
_____
_____

Household Composition

Please identify any family members living inside or outside of the home, as well as anyone living with you.

Name	Gender	Relationship	DOB and Age

Medical Information

Do you presently have any medical conditions we should be aware of, please list:

Have you been diagnosed with a mental illness? ☐ Yes ☐ No
If yes, please explain:

Do you have any allergies? ☐ Yes ☐ No
Explain:

Do you have any dietary restrictions? ☐ Yes ☐ No
If yes, please explain:

Please Complete Below for **ALL** medications you are currently taking:
All medications must be in Blister Packs and a copy of your current medications must be provided prior to entering Biidaaban Healing Lodge.

Medications	Dosage	What is it for? Last Used?	How is it administered? (e.g., oral, needle, nasal spray, etc)

Please Complete Below for ALL ***substances*** (Drugs, Marijuana, Alcohol, etc)

Substance	Frequency of Use	Date Last Used

Legal Matters

Do you currently have any court matters before the court or restrictions we need to be aware (probation, peace bonds, etc.)?
If you are on probation a copy of your conditions will need to be submitted in order to be eligible for programming at Biidaaban Healing Lodge. A signed consent to release of information also needs to be completed with your probation officer.

Have you been charged/convicted of a crime that was violent in nature?
☐ Yes ☐ No

Have you ever committed a serious or violent offence against an individual?
☐ Yes ☐ No

Program Details

***** Please note: There is a six-month waiting period between some programs. Please only select one program. If you want to attend another program after services are complete you can speak with our intake worker.***

Which program are you applying for?

☐ Reconnecting to Spirit (5-day Residential Program)
☐ Anger Solutions (7-day Residential Program)
☐ Healing from Grief and Loss (10-day Residential Program)
☐ Healing from Sexual Abuse (10-day Residential Program)

What services are you specifically looking for from Biidaaban Healing Lodge?

_____

_____

_____

Referrals can be made by our fax number **807-229-0308** or by email to **intake@biidaaban.com**
Please ensure that all documents are completed and sent for your application to be processed.

☐Residential Treatment Package (pgs. 1 – 5)
☐ Limits of Confidentiality (pg. 7)
☐ Consent for Referral/Intake (pg. 6)
☐Personal Information and consent notice (pg. 9)
☐ Consent to Release/Obtain Personal Health Information (pg. 10-11)
☐ Medical Information Form (pg. 12 – 15)

Consent for Referral/Intake

I, _____, understand that by signing this form, I have acknowledged consent to receive services and attend programming from Biidaaban Healing Lodge for myself. I have read and understand the information provided and that have given my permission to have an intake interview conducted in order to offer services. Furthermore, I understand that this in no way obligates me to Biidaaban Healing Lodge.

X _____

Client

X _____

Date

Limits of Confidentiality

Biidaaban Healing Lodge staff will explain the following information to you. Your signature indicates that you understand and accept the limits of confidentiality. Please feel free to ask any questions you may have pertaining to confidentiality and we will be happy to explain this form and the limits to confidentiality.

Sharing Information

I understand that Biidaaban Healing Lodge will be asking me for personal information and personal health information to ensure alignment of services. The purpose of the assessment is to develop a plan of care that will support my goals, wellness, and recovery. This information will be used to develop a plan of care that may include internal or external referrals and collection of information. This information will be kept in an electronic file. Biidaaban Healing Lodge uses a web-based client file system (EMHware) for the creation and storage of client clinical data. This system requires a username and unique individualized password that are provided only to the Biidaaban Healing Lodge staff member. No individual outside of Biidaaban Healing Lodge will have access to these files without your written consent. Furthermore, consent can be withdrawn at any time with a written request. Biidaaban Healing Lodge clients can request to access their own personal health records by submitting a written request.

I also understand that there are circumstances where confidential information is legal required to be shared without my written consent. There are as follows:

- **When a client is not capable of giving consent.**
- **If we believe that you are in immediate threat to self or others, we are obligated to report this to the proper authorities for the protection of all involved.**
- **We are required by law to report sexual abuse by another regulated health professional.**
- **Suspected or known abuse of a child under the age of 16 or under the age of 17 in the custody of child welfare.**

X _____ X _____

Client Date

The Personal Information Act

The Personal Health Information Protection Act, 2004, is a provincial law that governs the collection, use, and disclosure of personal health information within the health care system. The object is to keep personal health information confidential and secure, while allowing for the effective delivery of health care services. Under this legislation, health care providers and others who deliver health care services are collectively known as health information "custodians".

What is personal health information?

Personal health information includes any identifying information about an individual's health or health care history, such as your family medical history, details of a recent visit to your doctor, or your Ontario health card number.

Do health information custodians need my permission to access my personal health information?

Custodians are permitted to collect, use, and disclose your personal health information, on the basis of implied consent, for providing your health care.

What are health information custodians required to do?

Under PHIPA, health information custodians are required to: 1) collect only the information they need to do their job 2) take steps to safeguard your personal health information 3) take reasonable steps to ensure your health records are accurate and complete for the work they do 4) provide a written description of the practices they use to protect your information, and the name of the person to contact if you have any questions or concerns about your personal health records.

What are your rights under PHIPA?

PHIPA gives you the right to: 1) give permission (consent) to how your personal health information is collected, used, and shared 2) request access to your health records 3) make corrections to your records.

PHIPA: Service Ontario Information Line: 1-866-532-3162 (Toll-free)

Personal Information and Consent Notice:

This Notice and Consent is intended to inform you how we will collect, use, disclose, and destroy your personal information.

Your personal information may be collected formally, in writing, and informally. Only necessary information will be collected about you. We will collect, use, and disclose information about you for the following purposes: To develop plans of care and practice case management of your file; To enable accurate referrals are made; For anonymous statistical analysis of programs and services. The storage, retention, and destruction of your personal information complies with this agency's policy, applicable legislation and privacy protection protocols. We are willing to provide a copy of our policy to you at your request.

Your consent may be withdrawn at any time by written notice to this agency. You may access your own personal information or request corrections through a written request to this agency. This consent form will serve for all agency programs you access.

!, _____("The Individual") have read and understood the preceding notice and had it explained to me. I am aware how this agency will use my personal information. I am also aware of the steps taken by this agency to protect my information, when it is collected, used, or disclosed as well as how it will be stored and destroyed. I consent to the provisions of the preceding Notice.

X _____
Client

X _____
Date

X _____
Witness

X _____
Date

Consent to Obtain Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004
(PHIPA)

Please Fill Out for EACH agency/worker you want Biidaaban Healing Lodge to obtain information from

I, _____, authorize _____
Print your name Print name of Health Information Custodian

Date of Birth_____ Health Card:_____ Version_____
Mm/dd/yyyy

To obtain

☐ my personal health information consisting of:

(Describe the personal health information to be disclosed)

To _____ **Biidaaban Healing Lodge.**
(Print name and address of person requiring information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Client Name: _____

Telephone Number: _____
Alternate Number: _____

X _____ X _____
Client Date

Witness Name: _____

Telephone Number: _____
Alternate Number: _____

X _____ X _____
Witness Date

Consent to Release Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004
(PHIPA)

Please Fill Out for EACH agency/worker you want Biidaaban Healing Lodge to release information to

I, _____, authorize **Biidaaban Healing Lodge**
Print your name — Print name of Health Information Custodian

Date of Birth_____ Health Card:_____ Version_____
Mm/dd/yyyy

To release

☐ my personal health information consisting of:

(Describe the personal health information to be disclosed)

To _____
(Print name and address of person requiring information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Client Name: _____

Telephone Number: _____
Alternate Number: _____

X _____ X _____
Client — Date

Witness Name: _____

Telephone Number: _____

X _____ X _____
Witness — Date

Client Medical Information Form

Please have this form completed by your primary doctor or nurse practitioner. If this form is not completed your referral package will be deemed incomplete.

DATE OF EXAM: _____

Addressograph

Please complete this section in a **CLEAR** manner.
For physicians, please complete in **FULL.**

PATIENT'S NAME: _____ **How do you Identify? Male □**

DATE OF BIRTH: _____ **Female □**

STATUS CARD #: _____ **2-Spirited □**

HEALTH CARD #: _____

MEDICAL HISTORY (Please explain any 'YES' responses in section)

Conditions	Yes	No	If Yes, Explain?
Anemia	□	□	
Back Injury/ Problems	□	□	
Brain Injury	□	□	
Cardiovascular Problems	□	□	
Cognition Problems	□	□	
Chicken Pox	□	□	
Disease / Injury of Bones	□	□	
Diabetes/Hypoglycemia	□	□	
Ear, Nose, Throat Prob.	□	□	
Eating Disorders	□	□	

Eye Problems	☐	☐	
Epilepsy	☐	☐	
Fainting	☐	☐	
Hallucinations/Delusions	☐	☐	
Heart Problems	☐	☐	
Hepatitis (A,B,C) Indicate, if yes	☐	☐	
Respiratory Problems	☐	☐	
Gastrointestinal Problems	☐	☐	
Pancreatic Problems	☐	☐	
Kidney or Urinary Problems	☐	☐	
Learning Disability	☐	☐	
Tuberculosis	☐	☐	
Chronic Pain	☐	☐	
Sleep Disorders	☐	☐	
Withdrawal Symptoms	☐	☐	
Mental Health Challenges	☐	☐	
HIV/AIDS	☐	☐	
Sexually Transmitted Disease	☐	☐	
Allergies (Drug, Food, Other)	☐	☐	
Suicidal Ideations	☐	☐	

Current Medications Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. Please note: mood altering medications must be prescribed and monitored by a psychiatrist for management of a mental illness. If more space is required, attach a current medication list with the application.

Medication	Dose	Frequency	Start Date	End Date	Indication

Reminder to health professional: For the client's safety and well-being while attending our 'facility of healing' please ensure that they bring enough of their medications (in the original packaging from the doctor or pharmacist) for their time in treatment.

In your opinion, is this client medically stable and appropriate for admission to a residential healing program?

Yes □ **No** □

Does the client have any communicable diseases?

Yes □ **No** □

If yes, please list:

Communicable Disease	Condition and/or Treatment

Has there been any disease outbreaks in the client's region? (Tuberculosis/COVID-19/etc)

Yes □ **No** □

If yes, please explain:

Does the client need any special, physical or psychological needs or disabilities?

Yes □ **No** □

If yes, please explain:

In the past 6 months, has the client been using the medication appropriately?

Yes □ **No** □ **N/A** □

If no, please explain

Has the client been vaccinated for COVID-19?

No □ **Yes (1st Shot Only)** □ **Yes (2 shots)** □ **Yes (2 Shots plus booster)** □

A. PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Area	NO CONCERNS	Area	NO CONCERNS
Cardiovascular	□	Musculoskeletal System	□
Cognition	□	Neuropsychiatry	□
Ears, Nose, Throat (System Review)	□	Lymph Nodes	□
Eyes	□	Respiratory	□
Mental Health	□	Other: _____	□

Is the Client Pregnant? **No** □ **Yes** □ **How far along is the pregnancy?** __

Can the client attend sweats and/or long exposures to heat? **No** □ **Yes** □

CONTACT INFORMATION OF HEALTH PROFESSIONAL

HEALTH PROFESSIONAL'S FULL NAME (PRINT): _____
JOB TITLE: _____ DATE: _____
ADDRESS: _____
PROVINCE/TERRITORY: _____ POSTAL CODE: _____
PHONE: _____ FAX: _____
Email: _____ License Number # _____

HEALTH PROFESSIONAL'S SIGNATURE: _____

CLIENT CONSENT TO RELEASE INFORMATION
I hereby authorize the above-named health professional to release the information to the appropriate 'Healing facility' and Continuous Care Facilitator, as required my suitability for acceptance and admittance into the treatment program.

_____ _____
PARENT/LEGAL GUARDIAN/CLIENT SIGNATURE DATE

X _____
Medical Practitioner

X _____
Date