Residential Treatment Package

Please note, incomplete forms cannot be processed and will be returned.

Date:________________________________

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: ____

<u>Demographic Information</u>

First Name:		Last Name:
Current Address:		Mailing Address:
Primary Contact Number:	Alternative Contact Number:	Email:
Birthday:	Gender:	Preferred Pronouns:

Self Identification: ☐First Nation ☐ Metis ☐ Inuit ☐ Non-Status ☐ Other	First Nation Band:
	Status #:
	Health Card #:
	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? Orhave you been employed with Biidaaban Healing Lodge: ☐ Yes, I am/was an employee of Biidaaban Healing Lodge ☐ Yes, I have a family member or friend that is employed at Biidaaban Healing Lodge ☐ No

Family Background and History

Current Marital Status:
☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Widowed

Name of spouse/partner: ______________________________
Length of relationship: ______________________________

Do you have any dependent children? ☐ Yes ☐ No
Are there any child(ren) involved with agencies? ☐ Yes ☐ No
If yes, explain:

Parents

Mothers Name:	☐ Living ☐ Deceased
Fathers Name:	☐ Living ☐ Deceased
Step-Mothers Name:	☐ Living ☐ Deceased
Step-Fathers Name:	☐ Living ☐ Deceased

Children

Name:	☐ Biological ☐ Adopted ☐ Step	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Adopted ☐ Step	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Adopted ☐ Step	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Adopted ☐ Step	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Adopted ☐ Step	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Adopted ☐ Step	☐ Living ☐ Deceased

Siblings

Name:	☐ Biological ☐ Step/Half	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Step/Half	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Step/Half	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Step/Half	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Step/Half	☐ Living ☐ Deceased
Name:	☐ Biological ☐ Step/Half	☐ Living ☐ Deceased

Education and Employment Status

Education:
☐ Elementary ☐ Secondary ☐ Post Secondary ☐ Apprenticeship/Trades
Employment/Income:
☐ Employed (FT/PT) ☐ Unemployed ☐ OW ☐ ODSP ☐ Retired ☐ N/A
Do you require literacy assistance or have other learning needs? ☐ Yes ☐ No Explain:

Legal Issues

Please ensure to include a copy of any conditions for probation or parole. Applications missing this will be deemed incomplete.

Current/Pending Charges? ☐ Yes ☐ No
Currently on Probation? ☐ Yes ☐ No
Currently on Parole? ☐ Yes ☐ No
Do you have to attend court? ☐ Yes ☐ No
Have you been court ordered to attend? ☐ Yes ☐ No

Past Offences:
Please check all that apply and indicate date of offence beside the offence.

☐ Arson
☐ Assault
☐ Break & Enter
☐ Burglery
☐ Drug Charges
☐ Forgery
☐ Impaired Driving
☐ Manslaughter
☐ Murder
☐ Parole Violation
☐ Probation Violation
☐ Criminal Negligence causing death
☐ Robbery
☐ Sexual Assault
☐ Theft
☐ Weapons Offence
☐ Willful damage/mischief
☐ Possession of Stolen Property
☐ Other: ______________________________

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
If yes, please explain: ______________________________
Do you carry an Epi-Pen? ☐ Yes ☐ No

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

Please Complete Below for **ALL** medications you are currently taking:

Medication	Dose	Was this prescribed? What is it used for?	How is it administered? (e.g., oral, needle, nasal spray, etc)

All medications must be in Blister Packs and a copy of your current medications must be provided prior to entering Biidaaban Healing Lodge.

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

Substance	Frequency of Use	Date Last Used	Route of Administation?

Program Details

**** Please note: There is a six-month waiting period between the Healing from Grief and Loss and Healing from Sexual Abuse programs.***

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)

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 legally 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 ______________________________
Client

X ______________________________
Date

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
Date

Consent for Release of Personal Information

Please fill out this form for EACH agency/worker you want Biidaaban Healing Lodge to obtain/release information from/to

I,____, authorize and consent for the release of the following
(Name)

information or documentation pertaining to the records or any portion thereof as compiled by

____ regarding ______________________________________
(Name of Organization or Person with Information) (Name)

to be released to **Biidaaban Healing Lodge** for purposes regarding Admission to The Lodge.

I also authorize and consent for the release of the following information or documentation pertaining to the records or any portion thereof, as compiled by Biidaaban Healing Lodge to be released to

____.
(Name of organization/person to release to)

Specify Information Authorized to be released:
☐ Any and all information required for admission to Biidaaban Healing Lodge

____

____

____

____

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

Date: ____________________________ Signature: _____________________________________

Witness:___________________________ _______________________________________
. (Sign) (Print)

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 Date: