



Biidaaban Healing Lodge

REFERRAL AND CLIENT INFORMATION

Biidaaban Healing Lodge is a 12 bed, co-ed 5 or 7 -day residential treatment program. This package will provide the information necessary to apply for our programs.

Please check the program you are applying to:

<input type="radio"/> Grief and Abandonment	7 Day Cycle
<input type="radio"/> Healing from Sexual Abuse	7 Day Cycle
<input type="radio"/> Children of Trauma	7 Day Cycle
<input type="radio"/> Anger Solution's	5 Day Cycle
<input type="radio"/> Reconnecting to Spirit	5 Day Cycle

For fax purposes please keep this document 1 sided.

Fax to 807-229-0308 or Email intake@biidaaban.com

Enclosed are the following documents:

Intake/Referral Form:

- ❖ All areas must be completed.
- ❖ Court matters, documents and probation orders must be attached.
- ❖ Client and referral signatures are required.

Medical Forms:

- ❖ An updated medication list is required.

Release of Information:

- ❖ Client must specify referral worker and/or any other person(s) authorized to receive information.
- ❖ Client and referral worker signatures are required.

Personal Items Checklist:

- ❖ This document is for client information only.

Please read the following information before completing and sending an application:

Admission policy stipulates that:

- ❖ Clients whom are members of the 13 First Nations of the Robinson Superior Treaty area will be accepted as a priority.

Criteria for Acceptance

- ❖ We are not a medically equipped facility; clients on Methadone, Suboxone, Sublocade, Narcotics, or any antipsychotic medications will be reviewed and require support from family physician.
- ❖ Applicants who have been diagnosed with Bi-Polar Disorders, Personality Disorders, Major Depressive Disorders, FAS/FASD, brain injury and/or severe physically dependent persons will be reviewed case by case for suitability.
- ❖ Clients with legal involvement must provide all orders and conditions, court dates must not interfere with program and will be reviewed case by case.
- ❖ Clients must be 18 years of age.

Ineligible Clients

- ❖ Clients that are pregnant.
- ❖ Clients currently incarcerated and/or have not been out of custody for a minimum of thirty (30) days.
- ❖ Clients who have not maintained (14) days free of alcohol and/or drugs.
- ❖ Couples and immediate relatives cannot be accepted into the same program cycle; one may be considered for the following program cycle.

The following is the application process into Biidaaban's program cycle:

- ❖ Incomplete applications will be held for thirty (30) days before being discarded. It will be client's responsibility for ensuring application is completed in that time.

Completed Applications:

1. Client applications are received and entered our information system.
2. Intake worker reviews and screens application to determine eligibility for the potential client.
3. A telephone interview will be scheduled with the client and/or the referral worker.
4. Application is forwarded to the treatment team for decision of acceptance or alternative resources.
5. Once the treatment team's decision is made, a letter is sent stating approval or denial to the referral worker and/or client.

Additional Information:

- ❖ Please bring identification documents on intake day (Health card, Status card).
- ❖ All medication must be in blister packs.
- ❖ Medication must be prescribed by a physician.
- ❖ Vitamins and/or any other supplements not prescribed by a physician, must be in unopened containers.
- ❖ All medications (prescribed and non-prescribed) are secured and monitored by staff.
- ❖ Clients must bring sufficient supplies of personal items-toiletries, cigarettes, etc.
- ❖ Biidaaban supplies, Soap, Shampoo, Conditioner.
- ❖ Laundry machines and supplies are provided.
- ❖ All money and valuables of the client will be secured.
- ❖ All food (and other) allergies must be documented in the application package with supporting medical documents. Biidaaban Healing Lodge tries to accommodate food allergies as much as we can.
- ❖ Biidaaban Healing Lodge is equipped and monitored by security cameras.
- ❖ Transportation to and from Biidaaban Healing Lodge for any reason is the sole responsibility of the client.



Biidaaban Healing Lodge

INCOMPLETE APPLICATIONS MAY DELAY THE INTAKE PROCESS

Fax to 807-229-0308 or Email Intake@biidaaban.com

If information is not applicable, please indicate NA. Attach a separate sheet of paper if more space is needed.

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED

ADULT INTAKE/REFERRAL APPLICATION

A. General Information			
Date Application Received by Community Worker:		Date Application Received by Treatment Centre:	
Surname:	First Name:		Preferred Pronouns:
Date of Birth: (DD/MM/YYYY)	Age:	Gender:	Provincial Health Card Number:
Full Mailing Address:			Telephone Number:
Personal E-mail Address:			
Status Native/Metis/Non-Status:	Status Number:		Band Name:
Education: (Incomplete/Completed High School, College, University)			Employment Status:
Emergency Contact Name:	Emergency Contact Telephone Number:		Relationship to Emergency Contact:

Family/Relationships		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-law <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Does the client have dependent children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, do they have access to adequate childcare while client is in treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Are the children in care of Child Protection Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Does the client have other dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Parents		
Mothers Name:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Fathers Name:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Step-Mothers Name:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Step-Fathers Name:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Siblings		
Name:	<input type="checkbox"/> Biological <input type="checkbox"/> Step/Half	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Name:	<input type="checkbox"/> Biological <input type="checkbox"/> Step/Half	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Name:	<input type="checkbox"/> Biological <input type="checkbox"/> Step/Half	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Name:	<input type="checkbox"/> Biological <input type="checkbox"/> Step/Half	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Name:	<input type="checkbox"/> Biological <input type="checkbox"/> Step/Half	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Name:	<input type="checkbox"/> Biological <input type="checkbox"/> Step/Half	<input type="checkbox"/> Living <input type="checkbox"/> Deceased

Legal Status:		
Has the client been court ordered to attend treatment?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide details (include copy of legal order): 		
Is the client under any of the following legal conditions?	<input checked="" type="checkbox"/> Bail <input checked="" type="checkbox"/> Parole <input checked="" type="checkbox"/> Temporary Absence Order <input checked="" type="checkbox"/> Charges Pending <input checked="" type="checkbox"/> Restorative Justice <input checked="" type="checkbox"/> Probation <input checked="" type="checkbox"/> Other	
Has the client ever been charged with a criminal offence? If yes, please attach any order or conditions and list charge(s) and date(s) of offence(s): 		

Treatment History:

Has the client participated in a non-residential/community-based substance abuse program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client participated in a non-residential/community-based mental health program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client participated in a residential treatment program before?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please provide information on previous treatment experience:

Year	Treatment Centre	Program	Completed	Comments
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			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Reason(s) for currently requesting treatment:

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

Substance	Frequency of Use	Date Last Used	Route of Administration

Mental Health		
Provide the following information about the client's mental health status:		
Mental Illness		Describe
Has the client been diagnosed with a mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Is the client currently being treated for any mental health issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
If yes, is the client taking medication consistently and as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Previous suicide attempts?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
If yes, when?		
Hospitalized for suicide attempts?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
If yes, when?		
Currently suicidal?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Name of Psychiatrist and/or Psychologist, telephone number and address (if applicable):	Name: Title:	Telephone: Address:

Process/Behavioral Addictions	
Has the client experienced problems with any of the following?	
Process/Behavioral Addictions	Describe
Gambling (slots, cards, bingo, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown
Eating (obesity, anorexia, bulimia, etc.):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown
Sex (promiscuity, pornography, etc.):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown
Internet/Texting:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown
Video Games:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown
Shopping:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown

Other Issues/Needs

Does the client have cultural and/or spiritual beliefs and practices we should be aware of? If yes, please describe:	Δ Yes Δ No
Does the client have any literacy or learning needs we should be aware of? If yes, please describe:	Δ Yes Δ No
Are there any other significant issues we should be aware of? If yes, please describe:	Δ Yes Δ No
Does the client understand there is an expectation to fully participate and complete all programming sessions while in attendance.	Δ Yes Δ No

Does the client understand there is an expectation they have been alcohol and drug free for at least fourteen (14) days prior to admission to residential treatment? Clients must be out of incarceration for a minimum of thirty (30) days prior to admission? (Clients with less than the required days must notify the treatment centre prior to admission)	Δ Yes Δ No
Client's Stage of Readiness: Please choose one of the following:	
<input type="checkbox"/> Pre-contemplation – Not considering change; resistant to change. <input type="checkbox"/> Contemplation – Unsure of whether to change, chronic indecision. <input type="checkbox"/> Determination – Preparation; committed to changing behavior within one month. <input type="checkbox"/> Action – Begin changing behavior. <input type="checkbox"/> Maintenance – Behavior change has persisted for six (6) months or more	

Please identify all concerns/issues you are currently experiencing:

Δ Child Welfare Involvement Δ Ontario Works Assistance Δ Disability Assistance Δ Continuing Education Δ Dental Needs Δ Sleep-Wake Disorders Δ Financial Crisis	Δ Replacement of Identification Δ Report-in to Authorities Δ Reliable/Safe Housing Δ Relocating Δ Sexual Health Concerns Δ Eating Disorders Δ Family Court	Δ Food Security Δ Job Security Δ Re-entering the community Δ Homelessness Δ Adverse Effects of Medication Δ Other:
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Client Authorization	
I authorize the documentation of my information for this application process. I understand and agree to accept the program as described by Biidaaban Healing Lodge.	
Client Signature	Date
Referral Signature	Date

Referral Information		
First Name:	Surname:	
Agency:	Title/Position:	
Agency Address:	Telephone Number:	
Fax Number:	E-mail Address:	
Will you continue to see the client once he/she has completed treatment? If not, why?		<input type="checkbox"/> Yes <input type="checkbox"/> No
What other supports are available to the client in their community upon return from Biidaaban Healing Lodge?		
Name/Resource	Description of Support	



Biidaaban Healing Lodge Treatment Centre

MEDICAL AUTHORIZATION

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?

DATE OF BIRTH: _____

Male

STATUS CARD #: _____

Female

HEALTH CARD #: _____

2-Spirited

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

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 blister packaging from the doctor or pharmacist) for their time in treatment.

CONDITION	YES	NO	If YES, Explain
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinations/Delusions	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis (A, B, C) Indicate, if yes	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Pancreatic Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney or Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Withdrawal Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Challenges	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (Drug, Food, Other)	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal Ideations	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Back Injury/ Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Cognition Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
Disease / Injury of Bones	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes/Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	
Ear, Nose, Throat Prob.	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	

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:

Comm unicable 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

A. PHYSICAL EXAMINATION

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

Area	NO CONCERNs	Area	NO CONCERNs
Cardiovascular	<input type="checkbox"/>	Musculoskeletal System	<input type="checkbox"/>
Cognition	<input type="checkbox"/>	Neuropsychiatry	<input type="checkbox"/>
Ears, Nose, Throat (System Review)	<input type="checkbox"/>	Lymph Nodes	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>

Is the Client Pregnant? No Yes How far along is the pregnancy? _____

Can the client attend sweat 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



Medical Practitioner

Date

