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:

	Program	Cycle
o	Grief and Abandonment	7 Day Cycle
o	Healing from Sexual Abuse	7 Day Cycle
o	Children of Trauma	7 Day Cycle
o	Anger Solution's	5 Day Cycle
o	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: ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widowed		
Does the client have dependent children?	Δ Yes Δ No	
If yes, do they have access to adequate childcare while client is in treatment?	Δ Yes Δ No Δ Not Applicable	
Are the children in care of Child Protection Services?	Δ Yes Δ No Δ Not Applicable	
Does the client have other dependents?	Δ Yes Δ No	

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

Legal Status:	
Has the client been court ordered to attend treatment?	Δ Yes Δ No
If yes, provide details (include copy of legal order):	
Is the client under any of the following legal conditions?	Δ Bail Δ Parole Δ Temporary Absence Order Δ Charges Pending Δ Restorative Justice Δ Probation Δ 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?	Δ Yes Δ No
Has the client participated in a non-residential/community based mental health program?	Δ Yes Δ No
Has the client participated in a residential treatment program before?	Δ Yes Δ No
If yes, please provide information on previous treatment experience:	

Year	**Treatment Centre**	**Program**	**Completed**	**Comments**
			Δ Yes Δ No	
			Δ Yes Δ No	
			Δ Yes Δ No	
			Δ Yes Δ No	
			Δ Yes Δ 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?	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Is the client currently being treated for any mental health issues?	Δ Yes Δ No Δ Not Applicable Δ Unknown	
If yes, is the client taking medication consistently and as prescribed?	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Previous suicide attempts?	Δ Yes Δ No Δ Not Applicable Δ Unknown	
If yes, when?		
Hospitalized for suicide attempts?	Δ Yes Δ No Δ Not Applicable Δ Unknown	
If yes, when?		
Currently suicidal?	Δ Yes Δ No Δ Not Applicable Δ 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.)	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Eating (obesity, anorexia, bulimia, etc.):	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Sex (promiscuity, pornography, etc.):	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Internet/Texting:	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Video Games:	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Shopping:	Δ Yes Δ No Δ Not Applicable Δ Unknown	
Other:	Δ Yes Δ No Δ Not Applicable Δ Unknown	

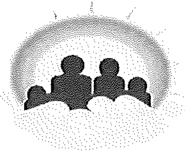
Other Issues/Needs	
Does the client have cultural and/or spiritual beliefs and practices we should be aware of? If yes, please describe:	ΔYes Δ No
Does the client have any literacy or learning needs we should be aware of? If yes, please describe:	Δ Yes Δ No
Are there any other significant issues we should 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:	
☐ Pre-contemplation – Not considering change; resistant to change. ☐ Contemplation – Unsure of whether to change, chronic indecision. ☐ Determination – Preparation; committed to changing behavior within one month. ☐ Action – Begin changing behavior. ☐ 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 Replacement of Identification	Δ Food Security
Δ Ontario Works Assistance	Δ Report-in to Authorities	Δ Job Security
Δ Disability Assistance	Δ Reliable/Safe Housing	Δ Re-entering the community
Δ Continuing Education	Δ Relocating	Δ Homelessness
Δ Dental Needs	Δ Sexual Health Concerns	Δ Adverse Effects of Medication
Δ Sleep-Wake Disorders	Δ Eating Disorders	Δ Other:
Δ Financial Crisis	Δ Family Court	

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?	Δ Yes Δ No
What other supports are available to the client in their community upon return from Biidaaban Healing Lodge?	
Name/Resource	**Description of Support**



RELEASE OF INFORMATION

Release Information			
I understand that any other information will not be released to any other person without my written consent unless they have a court order or are concerned with my medical treatment in an emergency. I also understand that I can withdraw my consent to the release/request of information at any time and that in any event this form will be void ninety (90) days from the date of my signature.			
Persons/Agencies *Please **specify Referral worker full name(s)** below*	**Yes**	**No**	**Client Initials**
1.			
2.			
3.			
4.			
5.			
Area of Disclosure			
Discharge Summary			
Continuing Care Plan			
Progress Reports			
Treatment Plan			
Other: Specify:			
I understand that any other information will not be released to any other person without my written consent unless they have a court order or are concerned with my medical treatment in an emergency. I also understand that I can withdraw my consent to the release/request of information at any time and that in any event this form will be void ninety (90) days from the date of my signature.			

Client Signature	**Date**
Referral Signature	**Date**
When, in the opinion of the healthcare provider, the physical and/or mental condition of a client prevents him/her from having the ability to understand the subject matter in respect of which consent is requested and from being able to appreciate the consequences of giving or withholding consent, authorization for disclosure of the information may be given by the client's next of kin.	
Signature of authorized person to sign in lieu of client	**Print Name**
Relationship to Client	**Date**

Biidaaban Healing Lodge Treatment Centre

MEDICAL AUTHORIZATION

Please have this form completed by your primary doctor or nurse practitioner. If this form is notcompleted 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: ________________________

DATE OF BIRTH: ________________________

STATUS CARD #: ________________________

HEALTH CARD #: ________________________

How do you Identify?

Male ☐

Female ☐

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	☐	☐	
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	☐	☐	
Anemia	☐	☐	
Back Injury/ Problems	☐	☐	
Brain Injury	☐	☐	
Cardiovascular Problems	☐	☐	
Cognition Problems	☐	☐	
Chicken Pox	☐	☐	
Disease / Injury of Bones	☐	☐	
Diabetes/Hypoglycemia	☐	☐	
Ear, Nose, Throat Prob.	☐	☐	
Eating Disorders	☐	☐	

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	☐	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