Nenqayni Wellness Centre Society

PO Box 2529 Williams Lake, BC V2G 4P2
www.nenqayni.com

Elder Application Package

Elders Wellness Program

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IMPORTANT: Application package to be completed and mailed, faxed, or scanned and emailed by referring agent. All sections must be completed. Indicate N/A if any information is not applicable. **Please print clearly.**

This is an application for: ☐ Session 1 ☐ Session 2

If client is willing to attend either session, check both boxes, please note that client will only be permitted to attend one (1) session.

Client is applying to program: ☐ As Individual ☐ With spouse (spouse name: ______________________________)

REFERRAL AGENT NAME	REFERRAL AGENCY		DATE
AGENCY ADDRESS	CITY	PROVINCE	POSTAL CODE
AGENCY TELEPHONE	AGENCY EMAIL	AGENCY FAX	

PART 1: IDENTIFYING INFORMATION

LEGAL SURNAME	FIRST NAME	PREFERRED NAME (IF DIFFERENT)	
DATE OF BIRTH (YYYY/MM/DD) ☐ MALE ☐ FEMALE	TELEPHONE	EMAIL	
ADDRESS	CITY	PROVINCE	POSTAL CODE
PERSONAL HEALTH NUMBER	SOCIAL INSURANCE NUMBER	STATUS NUMBER	BAND NAME

Emergency Contact Information: Client accepts Emergency Contact will be contacted in the event of an emergency.

EMERGENCY CONTACT SURNAME	EMERGENCY CONTACT FIRST NAME	RELATIONSHIP TO CLIENT
TELEPHONE	EMAIL	CITY OF RESIDENCE

PART 2: GENERAL INFORMATION

CURRENT MARITAL STATUS	CURRENT LIVING ARRANGEMENT (e.g., spouse and children, extended family, alone, etc.)

EMPLOYMENT STATUS

☐ FULL-TIME ☐ PART-TIME ☐ FULL-TIME SEASONAL ☐ PART-TIME SEASONAL ☐ TRAINING ☐ RETIRED ☐ STUDENT

☐ HOMEMAKER ☐ ON DISABILITY ☐ UNEMPLOYED ☐ OTHER: __________________________

CURRENT OCCUPATION(S): ______________________________________

INCOME SOURCE

☐ OCCUPATION ☐ INCOME ASSISTANCE ☐ FAMILY ☐ DISABILITY ASSISTANCE ☐ EMPLOYMENT INSURANCE ☐ NONE

☐ OTHER: __________________________

EDUCATION LEVEL ACHIEVED

☐ GRADE COMPLETED: _______ ☐ HIGH SCHOOL DIPLOMA ☐ TRADE SCHOOL ☐ UNIVERSITY/COLLEGE DEGREE IN-PROGRESS

☐ UNIVERSITY/COLLEGE DEGREE ☐ GRADUATE DEGREE

LANGUAGE(S) SPOKEN	Does Client require assistance with writing?	☐ YES ☐ NO
LANGUAGE PREFERRED	Does Client require assistance with reading?	☐ YES ☐ NO

PART 3: LEGAL STATUS

Client does **NOT** have a history with the legal system: ☐	IF NO legal history: Please **X** section.

Does Client have any current legal order(s) in place?	☐ YES ☐ NO	IF YES: Please specify type(s) of order(s) and ATTACH any documentation.
Has Client been court-ordered to attend treatment?	☐ YES ☐ NO	IF YES: Please provide details and ATTACH probation order if applicable.
Does Client have a no-contact order with his/her spouse?	☐ YES ☐ NO	IF YES: Please ATTACH the written exception form from probation officer. — Are any of Client's current or previous charges drug or alcohol related? ☐ YES ☐ NO
Does Client have any previous convictions/charges?	☐ YES ☐ NO	IF YES: Please list and provide dates.
Does Client have any pending charges/court dates?	☐ YES ☐ NO	IF YES: Please list and provide dates.

PROBATION OFFICER NAME	PROBATION OFFICER TELEPHONE	PROBATION OFFICER FAX

PART 4: SUBSTANCE USE HISTORY

Please specify with a star (✸) the substance(s) Client is particularly concerned about.

Type	Age of first use	How often used (daily/weekly/monthly)	Quantity	Date last used (YYYY/MM/DD)	Comments
Alcohol (beer, wine, spirits)					
Marijuana					
Hallucinogens (LSD/acid, mushrooms, PCP, ketamine)					
Cocaine					
Heroin					
Opiates (codeine, morphine, opium)					
Inhalants (glue, hair spray, gases, nitrites)					
Prescription drugs (specify: ______________ ______________________)					
Over-the-counter drugs (specify: _____________ _____________________)					
Tobacco					
Caffeine					
Other: ________________					
Other: ________________					

PART 5: TREATMENT HISTORY

Has Client participated in a residential treatment program before?	☐ YES ☐ NO	IF YES: Please provide information below.

Treatment Centre	Location	Start date/ End date (YYYY/MM/DD)	Issues/addictions worked on	Completed
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

IF any treatment program was NOT completed: Please provide details.

Has Client participated in a non-residential/community-based substance abuse and/or mental health program (e.g., relationship counselling, anger management, depression)?

☐ Currently
☐ Previously
☐ No treatment history

IF YES: Please describe the type of program(s) and counselling provided.

PART 6: MOBILITY AND PERSONAL CARE

Does Client have any difficulty with or concerns regarding their level of personal mobility while in treatment (e.g., walking, sitting/rising, standing)?	☐ YES ☐ NO	IF YES: Please explain.
Does Client have any difficulty with or concerns regarding carrying out their daily personal care needs while in treatment (e.g., showering, using the washroom)?	☐ YES ☐ NO	IF YES: Please explain.

Nenqayni Wellness Centre Society does **NOT** provide one-on-one aides or support workers for clients who require daily support for their personal care needs or mobility. Is Client able and willing to be fully self-sufficient for his/her own care for the duration of the treatment program?

☐ YES
☐ NO

SPECIFIC NEEDS
Please note any special needs, physical limitations, or other concerns Client may have about his/her stay at the facility.

PART 7: BACKGROUND INFORMATION

Please indicate which (if any) of the following issues have been a part of Client's life and provide pertinent details in associated space. If Client is unsure or answer is unknown, please circle (○) check-box.

Social Functioning			
☐ Physically aggressive, abusive, or threatening behaviour		☐ Sexually aggressive behaviour or promiscuity (verbal or physical)	
☐ Verbally aggressive, abusive, or threatening behaviour		☐ Uncontrollable outbursts of anger	
☐ Depression		☐ Suicidal ideation	
☐ Suicide attempt(s) (please specify dates)		☐ Self-harm or mutilation	
☐ Running away		☐ Recklessness/unhealthy risk taking	
☐ Severe and debilitating anxiety		☐ Co-dependent/controlling	
☐ Eating disorder (please specify)		☐ ADHD (Attention Deficit Hyperactivity Disorder)	
☐ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects)		☐ Mental disorder	
☐ Intellectual developmental disability		☐ Difficulty following rules or regulations	
☐ Dislike of or disregard for authority figures		☐ Substance withdrawal (detoxification)	
☐ Medical complications that may affect treatment		☐ Other destructive behaviours (e.g., vandalism, arson)	

Withdrawal Symptoms		Process Addiction	
☐ Blackouts		☐ Gambling (e.g., slots, cards, Keno, bingo)	
☐ Hallucinations			
☐ Nausea/Vomiting		☐ Eating (e.g., obesity, anorexia, bulimia)	
☐ Seizures			
☐ Shakes		☐ Sex (e.g. promiscuity)	
☐ DTs (Delirium Tremens)		☐ Internet surfing or texting	

PART 8: TREATMENT NEEDS

How would Client classify their religious affiliation or beliefs?

☐ Traditional Native ☐ Roman Catholic ☐ Other Christian ☐ Non-religious ☐ Other: _________________

Nenqayni Wellness Centre Society strongly believes in a holistic approach to treatment that involves cultural activities (e.g., daily smudges, sweat lodge, drumming) and activities focused on spirituality and mindfulness (e.g., yoga, meditation). Is Client willing to engage in these practices or open to learning more about them?

☐ YES

☐ NO

TRAUMA

Please note any recent or past traumatic events that Client feels comfortable disclosing at this time.

SPECIFIC TREATMENT

Please note any specific goals or needs (i.e., cultural, spiritual, mental, emotional, physical) that Client has for his/her treatment.

OUTSIDE RESOURCES AND AFTERCARE

Please list any supportive persons (e.g., relatives, counsellors) and agencies in the community that Client has (or could have) contact with that may aid Client in his/her ability to succeed in treatment and assist with aftercare. Please include any relevant contact information. Client accepts that Nenqayni may make contact with these persons or agencies to coordinate support.

RECOMMENDATIONS

Please add any further insights that Client feels may assist the intake worker and treatment team in assessing the suitability of Client for treatment. Please ATTACH any supporting letters or documents.

Elders Wellness Program: Client Agreements

IMPORTANT: Client's acceptance of these agreements is **required** for admission into the Elders Wellness Program. By signing this page, Client acknowledges that he/she has read and understood these agreements. Any questions or concerns may be directed to either of the program intake coordinators: Joan Evans, (250) 989-0301 ext. 206 or jevans@nenqayni.com; Sharon Duffy, (250) 989-0301 ext. 223 or sduffy@nenqayni.com.

To **referral agent**: Please ensure that, in conjunction with clearly verbally communicating these agreements, Client is afforded the opportunity to review this document and ask for any necessary clarifications.

- I certify that all of the information presented in this Elders Wellness Program (EWP) Intake Package and to Nenqayni Wellness Centre Society (NWCS) at the time of intake or any time thereafter is complete, accurate, and true in every respect. I understand that providing false, misleading, or incomplete information to NWCS may be viewed as a breach of these agreements. I understand that any breach of these agreements in the view of NWCS staff may result in my dismissal from the Elders Wellness Program.

- I agree to give up all electronic devices, medications, or any disallowed personal items as will be described to me in the EWP guidelines to NWCS staff upon my arrival and that the nondisclosure or possession of any disallowed items or contraband shall be viewed as a breach of these agreements.

- I agree to commit myself to the EWP and all therapeutic activities and practices contained therein to the best of my ability and in accordance with my personal spiritual or religious beliefs.

___________________________________	___________________________________
Client Signature	Witness Signature
___________________________________	_______________________
Client Name (PRINT)	Date

Current Medical Assessment Forms

IMPORTANT: Medical assessment to be completed by Client's primary care provider (i.e., GP, NP). All sections must be completed. Indicate N/A if any information is not applicable. **Please print clearly.**

REFERRAL AGENT NAME	REFERRAL AGENCY		
AGENCY ADDRESS	CITY	PROVINCE	POSTAL CODE
AGENCY TELEPHONE	AGENCY EMAIL	AGENCY FAX	

PATIENT INFORMATION				
LEGAL SURNAME	FIRST NAME	MIDDLE NAME		
DATE OF BIRTH (YYYY/MM/DD) ☐ MALE ☐ FEMALE	TELEPHONE	PERSONAL HEALTH NUMBER	STATUS NUMBER	
ADDRESS		CITY	PROVINCE	POSTAL CODE

To **Physician**:

The aforementioned client is to be medically assessed as a requirement for participation in a residential treatment program at **Nenqayni Wellness Centre Society** in Williams Lake, BC for Alcohol/Drug/Inhalant Abuse/Dependency.

Nenqayni requires each client to have a complete physical examination prior to admission. **Please ATTACH any relevant: lab results, operative reports or consultations, including psychological or educational psychology reports.**

Informed Consent

(Please complete Informed Consent with Client.)

I, ______________________________ (client name), do hereby request and permit my physician,

Dr. ______________________________, to release medical facts and assessments about myself to Nenqayni Wellness Centre Society and the above named referral agency.

____ ________________________

Client Signature Date

MEDICAL HISTORY

Please list all current and past medical conditions.

Does client have recent history (3 months) of lice, scabies, or any other infestation?	☐ YES ☐ NO	IF YES: Please specify, including dates and current state of condition.
Does client have history of seizures?	☐ YES ☐ NO	IF YES: Please specify, including date and cause(s) of last occurrence.

Does client have any impairments or disabilities impacting functional capacity? Please describe.

Hearing impairment	☐ YES ☐ NO	
Visual impairment	☐ YES ☐ NO	
Mobility impairment	☐ YES ☐ NO	
Other:	☐ YES ☐ NO	

SURGICAL HISTORY

Please list any previous surgical procedures, year performed, and reason.

SEXUAL HEALTH HISTORY

Does client currently have any STDs?	☐ YES ☐ NO	IF YES: Please specify.

Hepatitis C	☐ YES ☐ NO	IF HEPATITIS C/HIV POSITIVE: Please comment regarding ongoing care requirements.
HIV/AIDS	☐ YES ☐ NO	

PSYCHIATRIC HISTORY

Please provide brief history of diagnoses, therapeutic management, and any hospitalizations.

Current and/or previous suicidal ideation and/or attempts: ☐ YES ☐ NO

IF YES: Please elaborate on stability and appropriateness toward rehabilitation.

MEDICATIONS

Please list all current medications, dose, frequency, and reason for taking.

Insulin carrier: ☐ YES ☐ NO Inhaler carrier: ☐ YES ☐ NO

ALLERGIES

Please list all drug, environmental, or food allergies and associated reaction(s).

EpiPen Carrier: ☐ YES ☐ NO IF YES: EpiPen expiry date: ___________________

FUNCTIONAL INQUIRY

Please comment on any abnormalities regarding review of symptoms.	
Skin	
HEENT	
Respiratory	
CVS/PVD	
GI/GU	
MSK	
Neurological	
Endodontic	
Psychiatric	

PHYSICAL EXAMINATION

Please comment on any abnormalities during physical examination.

Height: _______ Weight: _______ BP: _________ HR: _________

Skin	
HEENT	
Respiratory	
CVS/PVD	
GI/GU	
MSK	
Neurological	
Endodontic	
Psychiatric	

ADDITIONAL CLINICAL COMMENTS

Do you have any comments, suggestions, or insights that might be helpful in terms of Client being physically (moderate physical exercise) and mentally able to participate in group and one-on-one counselling (e.g. hearing problems) and living in residence for the duration of the program?

Are there any issues prior to and/or during treatment that require follow up? Please describe.

Is there any prescribed medication(s) required during treatment? Please specify and provide instructions

IMPORTANT: Client accepts that NO prescription medications will be administered by Nenqayni staff without presenting a valid prescription.

Based on the above history and physical examination that I have performed, I find

_____________________________________ (client name) to be

☐ **FIT** ☐ **NOT FIT** to attend treatment.

_________________________________ _______________________

GP/NP Signature Date

____

GP/NP Name (PRINT)

Office/clinic address (please use stamp if available):

To **primary care provider (GP/NP)**: Please refer the remainder of this medical assessment package to the appropriate nurse for completion. Thank you.

TB SCREEN

IMPORTANT: TB testing is **REQUIRED** before participating in a residential treatment program. Please establish that TB testing has been completed and results are forwarded to Nenqayni Wellness Centre Society.

To Nurse: Please ensure that the following is filled out as completely as possible. ATTACH any copies of any relevant records.

Has a Tuberculosis screening test been done for this client? ☐ **YES** ☐ **NO**

Test result: ☐ **POSITIVE** ☐ **NEGATIVE** **Date of test:** _______________

Chest X-ray: ☐ YES ☐ NO Interpretation:

Prophylaxis: Date started: _______________

Has Client had any or all Hepatitis B immunizations? ☐ YES ☐ NO

IF YES: How many?

Next due: _______________