Nenqayni Wellness Centre Society
PO Box 2529 Williams Lake, BC V2G 4P2
www.nenqayni.com

Adult Application Package
Family Alcohol and Drug Program
Joan Evans, Intake Coordinator: jevans@nenqayni.com
Phone: (250) 989-0301 Ext. 206 / Fax: (250) 989-0307

Family Alcohol and Drug Program Checklist

Please detach this page from the Application Package, and use it to ensure that all necessary and relevant documents are included and that this Package is filled out in its entirety before submission to Nenqayni.

APPLICATION PACKAGE

- ☐ If a **supervision order** is necessary for parent to attend treatment with children, it has been attached.
- ☐ If Client has a **no-contact order** with a spouse they are attending treatment with, a written exception from probation officer has been attached.
- ☐ Any applicable or relevant **legal orders and documentation** pertaining to Client have been attached.
- ☐ The **Medical Assessment Package** section (pages 8-14) has been completed by Client's primary care provider.
- ☐ **Prescriptions** have been filled out for any medications Client intends to take while at Nenqayni.
- ☐ All medications and vitamins that Client intends to bring to Nenqayni have been **blister packed**.
- ☐ **TB screen** has been completed within the previous two years and results attached.
- ☐ Application Packages completed for **each** family member attending treatment: **Adult** Application Package for adults and **Dependant** Application Package for children.

DOCUMENTATION

- ☐ Photocopies of the following identification materials have been attached for all attending family members:
  - ☐ CareCard or BC Services Card
  - ☐ Birth Certificate
  - ☐ Treaty Status Card
  - ☐ Social Insurance Card
- ☐ All previous assessments and/or the most recent and relevant information regarding the following have been attached if applicable:
  - ☐ Psychological assessments
  - ☐ Social history
  - ☐ Educational assessments
  - ☐ Medical/Psychiatric assessments
  - ☐ Predisposition report

PRIOR TO PROGRAM

- ☐ Client dry/clean for at least **14 days** prior to entering program.
- ☐ For adult clients entering program, **six counselling sessions** completed within six months of program intake date.
- ☐ Arrangements have been made regarding **grocery funds** for every breakfast and all weekend meals; funds can be brought with Client or be made available by bank transfer as needed.
- ☐ **Suitable clothing** for the season has been packed; clothing and footwear appropriate for sweat lodge ceremonies, working out, and swimming are required for the whole family.

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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.**

Client is applying to program as a: ☐ Single mother ☐ Couple: *Spouse name: _____

*Please note that **both** clients applying to Couples Program are required to fill out separate and individual Adult Application Packages.

Program start date(s) Client is willing to enter treatment at (*MM/DD*): _____

If Client is flexible and willing to enter treatment at any of multiple program start dates, please list all viable dates; however, Client will only be permitted to attend one session.

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: MARITAL/FAMILY INFORMATION

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

IMPORTANT: Please ensure a **Dependant Application Package** is completed for **each** child that will be attending with Client.

Total number of dependent children: _____ Age(s):	Are children currently in Client's care? ☐ YES ☐ NO	IF NO: Please specify current caregiver and relationship to Client (e.g., grandmother, MCFD).
Total number of children attending treatment with Client: _____	IF NOT all dependent children attending with Client: Please describe care plan and caregiver for unattended children.	Child 1: Child 2: Child 3:
Has Client been mandated by the Ministry of Children and Family Development to attend family counselling as a prerequisite for children to return to Client's care? ☐ YES ☐ NO		IF YES: Please **ATTACH** the supervision order and any other relevant documentation.
Have any of Client's children been previously apprehended? ☐ YES ☐ NO	IF YES: Please specify which child, date(s), and duration.	

SOCIAL WORKER NAME	SOCIAL WORKER OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE
SOCIAL WORKER TELEPHONE	SOCIAL WORKER FAX	SOCIAL WORKER EMAIL		

PART 3: GENERAL INFORMATION

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 4: 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 5: 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 6: 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

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 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 involving medicine wheel teachings, 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., spiritual, mental, emotional, physical) that Client has for their treatment.

SPECIFIC NEEDS

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

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.

Family Alcohol and Drug Program: Client Agreements

IMPORTANT: Client's acceptance of these agreements is **required** for admission into the Family Alcohol and Drug Program. By signing this page, Client acknowledges that he/she has read and understood these agreements. Any questions or concerns may be directed to Joan Evans, Intake Coordinator, at (250) 989-0301 Ext. 206 or jevans@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 Family Alcohol and Drug Program (FADP) Adult 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 Family Alcohol and Drug Program.

- I agree to surrender 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 FADP 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

MEDICAL ASSESSMENT PACKAGE
Pages 8-14. To be completed by Client's primary care provider.

Current Medical Assessment Forms

IMPORTANT: Medical assessment to be completed by Client's primary care provider (i.e., GP, NP, community nurse). 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 **Primary Care Provider**:

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.**

This Medical Assessment Package shall be released to Nenqayni Wellness Centre's local physician Dr. Van Der Merwe in Williams Lake should client require medical attention during their duration of treatment.

Informed Consent

(Please complete Informed Consent with Client.)

I, _____ (client name), do hereby request and permit my physician, nurse practitioner, or community nurse _____, to release medical facts and assessments about myself to Nenqayni Wellness Centre Society and the above named referral agency.

_____ _____

Client Signature Date

MEDICAL ASSESSMENT PACKAGE

Pages 8-14. To be completed by Client's primary care provider.

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.

OBSTETRICAL HISTORY (IF APPLICABLE)

G _____ T _____ P _____ A _____ L _____		Last menstrual period: _____
☐ YES Is Client pregnant? ☐ NO	IF YES: How many weeks?	IF PREGNANT: Has Client had any previous miscarriages and/or problematic pregnancies? Please specify.

SEXUAL HEALTH HISTORY

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

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

PSYCHIATRIC HISTORY

Please provide brief history of DSM 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.

MEDICAL ASSESSMENT PACKAGE

Pages 8-14. To be completed by Client's primary care provider.

FOR MINORS (<18 YEARS OF AGE)

Any prenatal, intranatal, or postnatal complications?	☐ YES	☐ NO
Any substance use/abuse by mother during pregnancy?	☐ YES	☐ NO
Any concerns regarding growth and development for age?	☐ YES	☐ NO

IF YES to any of the above: Please elaborate on any conditions and any residual impairment and/or complication(s).

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: _____

MEDICAL ASSESSMENT PACKAGE

Pages 8-14. To be completed by Client's primary care provider.

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. All prescribed medication must be in blister packs prior to intake.

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):

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. If previous testing results are to be submitted, testing must have occurred within previous **2 years** for results to be valid.

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: _____