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

Dependant 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

- ☐ Any applicable or relevant **legal orders and documentation** pertaining to Child have been attached.
- ☐ The **Medical Assessment Package** section (pages 8-14) has been completed by Child's primary care provider.
- ☐ **Prescriptions** have been filled out for any medications Child intends to take while at Nenqayni.
- ☐ All medications and vitamins that Child intends to bring to Nenqayni have been **blister packed**.
- ☐ If Child is of appropriate age: **School Information** page has been completed, and Child is prepared to bring **eight weeks** of schoolwork with them.
- ☐ **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

- ☐ Child dry/clean for at least **14 days** prior to entering program.
- ☐ **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: This Dependent Application Package is intended only for dependent children that will be attending treatment with their parent/guardian(s). Individual application packages must be filled out for **each** child that will be attending. If program occurs during the school year, **children of appropriate age are expected to attend on-site school during day hours and bring enough schoolwork with them to last the duration of the program.** Children not of school age are expected to attend day care.

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.**

REFERRAL AGENT NAME	REFERRAL AGENCY	DATE

PART 1: IDENTIFYING INFORMATION

LEGAL SURNAME	FIRST NAME	PREFERRED NAME (IF DIFFERENT)

DATE OF BIRTH (YYYY/MM/DD) ☐ MALE ☐ FEMALE	NAME(S) OF PARENT/GUARDIAN(S) ATTENDING TREATMENT

ADDRESS	CITY	PROVINCE	POSTAL CODE

PERSONAL HEALTH NUMBER	SOCIAL INSURANCE NUMBER	STATUS NUMBER	BAND NAME

PART 2: LIVING SITUATION

Is Child currently under care of either or both attending parent(s)? ☐ YES ☐ NO

NAME(S) OF PRIMARY CAREGIVER(S)	RELATIONSHIP(S) TO CHILD

CURRENT LIVING ARRANGEMENT (e.g., with mom and all siblings, with grandparents and only one sibling, with foster parents, etc.)

Has Child been previously apprehended? ☐ YES ☐ NO	IF YES: Please specify date(s), and duration.

If Child NOT currently under care of either parent for any reason, please explain circumstances and current regularity of contact.

IMPORTANT: If either or both parent(s) do NOT currently have full custody of Child, please **ATTACH** notice from the Ministry of Children and Family Development in regards to the current conditions required, any relevant supervision orders, or visitation rights.

SOCIAL WORKER NAME	SOCIAL WORKER OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE

SOCIAL WORKER TELEPHONE	SOCIAL WORKER FAX	SOCIAL WORKER EMAIL

PART 3: EDUCATION INFORMATION

Is Child currently attending school? ☐ YES ☐ NO	IF YES: NAME OF SCHOOL ATTENDING	CURRENT GRADE LEVEL

IMPORTANT: Please ensure a **School Information Form** (page 5) is completed for Child, and **eight** weeks of schoolwork is supplied.

IF NO: Is Child currently attending day care, preschool, or kindergarten? ☐ YES ☐ NO

LANGUAGE(S) SPOKEN	Does Child require significant assistance with writing? ☐ YES ☐ NO

LANGUAGE PREFERRED	Does Child require significant assistance with reading? ☐ YES ☐ NO

CLIENT NAME

DEPENDANT

PART 4: LEGAL STATUS

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

Does Child have any current legal order(s) in place? ☐ YES ☐ NO	IF YES: Please specify type(s) of order(s) and ATTACH any documentation.
Does Child have any previous convictions/charges? ☐ YES ☐ NO	IF YES: Please list and provide dates.

IF YES to either: Are any of Child's current or previous charges drug or alcohol related? ☐ YES ☐ NO

Does Child 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

Child does **NOT** have a substance use history: ☐	IF NO substance use history: Please **X** section.

Please specify with a star (✸) the substance(s) Child's parent 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: BACKGROUND INFORMATION

Please indicate which (if any) of the following issues have been a part of Child's life and provide pertinent details in associated space. If Child or Parent 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 date(s))		☐ 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 7: TREATMENT NEEDS

How would Child 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 Child 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 Child feels comfortable disclosing at this time.

SPECIFIC NEEDS

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

RECOMMENDATIONS

Please add any further insights that Child or Parent has regarding Child's potential time at treatment with parent(s). Please ATTACH any supporting letters or documents.

CLIENT NAME

DEPENDANT

School Information

IMPORTANT: Please complete a copy of this form for each child that will be attending school while at Nenqayni, and ensure that each child brings **eight** weeks of schoolwork with them. If program occurs during the school year, **children of appropriate age are expected to attend on-site school during day hours.** Children not of school age are expected to attend day care.

Please request Child's teacher to fill out this form if possible. Date of form completion: _____

EDUCATION INFORMATION

LEGAL SURNAME	FIRST NAME	PREFERRED NAME (IF DIFFERENT)	DATE OF BIRTH (YYYY/MM/DD)

ADDRESS	CITY	PROVINCE	POSTAL CODE

PERSONAL HEALTH NUMBER	PERSONAL EDUCATION NUMBER	STATUS NUMBER	BAND NAME

PARENT NAME(S)

NAME OF SCHOOL CURRENTLY ATTENDING	SCHOOL DISTRICT #	SCHOOL TELEPHONE

☐ ELEMENTARY SCHOOL ☐ MIDDLE SCHOOL ☐ HIGH SCHOOL ☐ ALTERNATIVE SCHOOL
☐ CORRESPONDENCE SCHOOL ☐ HOMESCHOOL ☐ OTHER: _____

Is school located on a reserve? ☐ YES ☐ NO

TEACHER NAME	PRINCIPAL NAME

Does Child generally receive one-on-one support in school or have some other nontraditional arrangement?	☐ YES ☐ NO	IF YES: Please describe arrangement (e.g., full-day support, half-day support, etc.)
Does Child have an Individual Education Plan in place?	☐ YES ☐ NO	IF YES: Please briefly describe and ATTACH any documentation
Does Child have a Student Safety Plan in place?	☐ YES ☐ NO	IF YES: Please briefly describe and ATTACH any documentation
Does Child have any previous academic or behavioural assessments on file?	☐ YES ☐ NO	IF YES: Please indicate which and ATTACH any documentation
Has Child ever received counselling through school?	☐ YES ☐ NO	IF YES: Please briefly describe and indicate date(s)
To your knowledge, has MCFD or a case worker been involved in Child's education?	☐ YES ☐ NO	IF YES: Please briefly describe and indicate date(s)

SPECIAL CONSIDERATIONS
Please make note of any special educational needs or behavioural issues teachers should be made aware of.

COMMENTS

MEDICAL ASSESSMENT PACKAGE
Pages 7-13. To be completed by Client's primary care provider.

Current Medical Assessment Forms

IMPORTANT: Medical assessment to be completed by Child'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 7-13. 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 7-13. 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 7-13. 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	

MEDICAL ASSESSMENT PACKAGE

Pages 7-13. To be completed by Client's primary care provider.

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: _____

FOR DEPENDENT CHILDREN

Was the postnatal follow up done for this child? ☐ YES ☐ NO

IF YES: Briefly explain the findings, present health status, and growth and development of the youth.

Is there an immunization schedule on file for this child? ☐ YES ☐ NO Up to date: _____

IF YES: What is presently required, and will this be administered prior to entry into the treatment program?