Treatment Centre Adult Referral Application Package

First Nations Health Authority
Health through wellness

January 2025

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Inclusion Criteria

INCLUSION	Carrier Sekani Family Services	Gya' Wa' Tlaab HealingCentre	Kackaamin	' Namgis TreatmentCentre	Nenqayni Wellness Centre	North Wind Wellness Centre	Round Lake Treatment Centre	Tsow-Tun Le Lum Society	Wilp Si' Satxw House ofPurification
Opioid Replacement Therapy	√	√			√	√	√		√
Family Program			√		√				√
Couples Program			√						√
Pregnant	√				√	√	√	√	√
Co-ed	√		√	√		√	√	√	√
Men-only sessions		√	√	√					√
Women-only sessions			√	√					√
Youth-only sessions					√[1]				√
Corrections Program						√		√	√
Barrier Free (person with ability challenges)			√				√	√	√
Alcohol-free	14 Days	Minor with-drawal	3 Weeks	14 Days	14 Days	14 Days	14 Days	14 Days	14 Days
Other Substance-free	14 Days	Minor with-drawal	3 Weeks	14 Days	14 Days	14 Days	14 Days[2]	14 Days	14 Days
Requires signed Rules and Regulations with Application[3]						√			

[1] Female-Youth Only
[2] Note: RLTC requires applicants to be 5 months free of Crystal Meth in order to attend their programs
[3] Please visit their website to review and complete *Rules and Regulations* with applicant and submit to Centre

Applicant Name: _____
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Treatment Centre Descriptions

CARRIER SEKANI FAMILY SERVICES	**Carrier Sekani Family Services** P.O. Box 1219 Vanderhoof, B.C. V0G 2A0 https://www.csfs.org/services/addictions-recovery-program Telephone: (250) 567-2900 Toll-free: 1-866-567-2333 Fax: (250) 567-2975	Length: 4-week OAT: Yes Family Program: No Couples Program: No Gender: Co-ed Pregnant: Yes (2nd Tri.) Substance free: 14 days Residential Treatment Program only April - October
	Gya'Wa'Tlaab Healing Centre P.O. Box 1018 Haisla, B.C. V0T 2B0 https://www.gyawatlaab.ca/ Telephone: (250) 639-9817 Fax: (250) 639-9815	Length: 6/7/8-week OAT: Yes Family Program: No Couples Program: No Gender: Men-only Pregnant: N/A Substance Free: Minor Withdrawal
Kackaamin FAMILY DEVELOPMENT CENTRE	**Kackaamin** 7830 Beaver Creek Road Port Alberni, B.C. V9Y 8N3 https://www.kackaamin.org/ Telephone: (250) 723-7789 Fax : (250) 723-5067	Length: 6-week OAT: No Family Program: Yes Couples Program: Yes Gender: Co-ed, Men- & Women-only Pregnant: No Substance Free: 3 weeks See website for children and youth applications
	'Namgis Treatment Centre P.O. Box 290 Alert Bay, B.C. V0N 1A0 http://www.namgis.bc.ca/health-services/treatment-centre/ Telephone: (250) 974-5522 Fax: (250) 974-2257	Length: 6-week OAT: No Family Program: No Couples Program: No Gender: Women- & Men-only Pregnant: No Substance Free: 14 days
NENQAYNI	**Nenqayni Wellness Centre** P.O. Box 2529 Williams Lake, B.C. V2G 4P2 https://nenqayni.com/ Telephone: (250) 989-0301 Fax: (250) 989-0307	Length: 7/8-week OAT: Yes Family Program: Yes Couples Program: Yes, with children Gender: Couples with Children Pregnant: Yes Substance Free: 14 days See website for children and youth applications

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	North Wind Wellness Centre *Mailing Address* Box 2480 Station A Dawson Creek, BC V1G 4T9 *Physical Address* 5524 235 Rd Farmington, BC V0C 1N0 https://northwindwellnesscentre.ca/ Telephone: (250) 843-6977 Fax: (250) 843-6978	Length: 45-day OAT: Yes Family Program: No Couples Program: No Gender: Co-ed Pregnant: Yes Substance free: 14 days See website to download & submit signed *Rules & Regulations*
	Round Lake Treatment Centre 200 Emery Louis Road Armstrong, B.C. V0E 1B5 http://roundlaketreatmentcentre.ca/ Telephone: (250) 546-3077 Fax: (250) 546-3227	Length: 6-week OAT: Yes Family Program: No Couples Program: No Gender: Co-ed Pregnant: Yes (2nd Tri.) Substance free: 14 days (Crystal Meth = 5 mnths) See website for information on Recovery Home
	Telmexw Awtexw Treatment Centre *Mailing Address* 4690 Salish Way Agassiz, B.C. V0M 1A1 *Physical Address* 16300 Morris Valley Rd Agassiz, BC V0M 1A1 http://www.stsailes.com/telmexw-awtexw Telephone: (604) 796-9829 Fax: (604) 796-9839	**OUTPATIENT/ COMMUNITY-BASED**
	Tsow-Tun Le Lum Society *Mailing Address:* PO Box 308 Stn Main *Physical Address:* 2850 Miller Rd Duncan B.C. V9L 3X5 http://www.tsowtunlelum.org/ Telephone: (250) 390-3123 Fax: (250) 390-3119	*Thuy Na Mut (A&D) Program* Length: 40-day OAT: No Family Program: No Couples Program: No Gender: Co-ed Pregnant: Yes (up to 3rd trimester) Substance free: 14 days See website for information on how to apply to the Kwunatsustul Program (Trauma/Grief/Codependency)
	Wilp Si'Satxw House of Purification Box 429 Cedarvale-Kitwanga Road Kitwanga, B.C. V0J 2A0 https://www.wilpchc.ca/ Telephone: (250) 849-5211 Fax: (250) 849-5374	Length: 42-day, 2 eight- week programs OAT: Yes Family Program: Yes Couples Program: Yes Gender: Co-ed, Men- & Women-only Pregnant: Yes (2nd Tri.) Substance free: 14 days

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Treatment Centre Adult Referral Application Package

Package Completion Process and Check List

Please note:

- This package is intended to be completed by a community support team member or a medical professional in collaboration with the applicant.
- Before submitting to the identified Treatment and Healing Centre(s) for processing, please ensure the following tasks are completed. **Please submit pages 5 – 12 only.**

☐ Review the FNHA-funded Treatment Centre Descriptions and inclusion criteria

☐ Identify the Treatment and Healing Centre(s) the applicant is applying to and the specific program if applicable (*Section 1, Page 5)*

☐ Complete the included referral package

Blue Sections (*Pages 5 - 9*)
To be completed by a referral worker in collaboration with the applicant

- ☐ Consent for Release of Treatment Information (*Page 5*)
- ☐ Referral Worker Information (*Page 6*)
- ☐ Applicant's Personal Information (*Page 6*)
- ☐ Income and Education (*Page 7*)
- ☐ Legal Assessment (*Page 7*)
- ☐ Family and Living Arrangements (*Page 8*)
- ☐ Wellness (*Page 8*)
- ☐ Substance Use History (*Page 8*)
- ☐ Treatment History (*Page 9*)
- ☐ Additional Information (*Page 9)*

Red Sections (*Pages 10 – 11*)
To be completed by a medical professional. Note: Referral Agent contact information required on Page 11.

- ☐ Medical Assessment (*Page 10*)
- ☐ Additional Medical Questions: Tsow-Tun Le Lum (*Page 11*)
  Only to be completed for applicants to Tsow-Tun Le Lum Society

Green Section (*Page 12)*
To be completed by a referral worker in collaboration with the applicant
Only to be completed if applicants are applying to the following Treatment and Healing Centres

- ☐ Appendix A (*Page 12*)
  Only to be completed for applicants to:
  - ○ Round Lake Treatment Centre
  - ○ Tsow-Tun Le Lum Society
  - ○ Kackaamin Family Development Centre
  - ○ North Wind Wellness Centre
  - ○ Gya'Wa'Tlaab Healing Centre

☐ Include the following collateral information if available and applicable:

- ☐ Document to show mandate to attend Treatment
- ☐ Parole/Probation/Release/Undertaking Order(s)
- ☐ Mental Health Assessment
- ☐ Tuberculosis Test Results/Chest X-Rays (if applicable)

☐ If applying to family program at Kackaamin and/or Nenqayni Wellness Centre, please visit their websites for the applicable applications for dependents and families.

☐ In consultation with the applicant, please complete the participatory agreements found at the specific Treatment and Healing Centre Websites, if applicable to where the applicant is applying to (identified in Inclusion Criteria, *Page 1*)

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Section 1: Treatment Centre Selection

Please identify your top choices (1 being top choice) for Treatment Centres you are applying to.

#	Treatment Centre Name	Specific Program (if applicable)
1		
2		
3		

Section 2: Consent for Release of Treatment Information

Release of confidential information between treatment centre staff and other organization or agencies.

I_____(print applicant's name), hereby give permission for the identified Treatment Centre staff (Section 1) to contact the identified individuals listed below for the release of information in regard to pre-treatment information, attendance verification, progress during treatment, aftercare planning, final discharge report, and/or emergency situations. By using this form, I also understand that I am providing my consent for the intake workers at the Treatment Centres listed on pages 2 and 3 of this document to discuss the information within this application package to support the referral process and ensure the most appropriate treatment plan is established.

_____ Referral Worker or assigned agency alternate	_____ Organization	Phone:_____ Email:_____ Fax: _____	☐ Pre-Treatment Information ☐ Attendance Verification ☐ Progress during Treatment ☐ Aftercare Planning ☐ Final Discharge Report
_____ Individual #2 E.g. Probation Officer	_____ Organization	Phone:_____ Email:_____ Fax: _____	☐ Pre-Treatment Information ☐ Attendance Verification ☐ Progress during Treatment ☐ Aftercare Planning ☐ Final Discharge Report
_____ Emergency Contact	_____ Relationship to Applicant	Phone:_____ Email:_____ Fax: _____	☐ Attendance Verification ☐ Aftercare Planning ☐ Emergency Situation ☐ Can be contacted after hours
_____ Emergency Contact	_____ Relationship to Applicant	Phone:_____ Email:_____ Fax: _____	☐ Attendance Verification ☐ Aftercare Planning ☐ Emergency Situation ☐ Can be contacted after hours

Applicant Signature:	Date:
Referral Worker's Signature:	Date:

NOTE: This form is applicable for one year after signed and dated. **The applicant may change or revoke this release at any time by giving notice to the Treatment Centre in writing.**

Section 3: Referral Worker Information

Date of Assessment/Referral:	Referral Worker Name:	Title/Position:
Organization/Agency Name:	Email:	Fax:
Address:	City, Province:	Postal Code:

Is the applicant receiving supports and resources from you? ☐ Yes ☐ No

Are there supportive services available to applicant upon discharge? ☐ Yes ☐ No

Has the applicant completed pre-treatment and/or healing sessions (e.g., AA, NA, Counselling, etc.)?
☐ Yes ☐ No
If yes, please explain what type of support and how many sessions have been completed:

Where does the applicant go in their community for support?

Section 4: Personal Information

4.1 Basic Information

Last Name	First Name Middle Name	Preferred Name
Birthdate (*DD/MM/YYYY*)	Telephone	Cellphone (if applicable)
Current Address	City, Province	Postal Code
☐ On Reserve ☐ Off Reserve	Email:	

Self-Identified Gender (select all that apply):
☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Two-Spirit ☐ Questioning ☐ My Gender is _____
Preferred Pronoun:
☐ He ☐ She ☐ They ☐ My Pronoun is:_____
If you identify as transgender, non-binary, or Two-Spirit, please inform us what residential space the applicant would prefer to stay within: ☐ Male ☐ Female

Indigenous Identity: ☐ Status ☐ Non-Status ☐ Métis ☐ Inuit ☐ N/A

Status Number (if applicable)	Band Name (if applicable)	Treaty Community (if applicable)
Personal Health Number	Marital Status: ☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

Has applicant been mandated to attend treatment? ☐ Yes ☐ No
If yes, by whom? _____
Must attach any applicable documents

4.2 Funding Resources

Have funding options been explored? ☐ Yes ☐ No Note: Funding resources must be in place prior to attending
If yes, provide details *(e.g. Corrections, Employer, FNHA, self, Band, etc.):*

Does the applicant have funding for travel to and from treatment?	☐ Yes ☐ No
Have travel arrangements been arranged?	☐ Yes ☐ No

Section 5: Income and Education

Source of income (employed, social assistance, disability, etc.)?

Current occupation:
☐ Employed full- time ☐ Employed part-time ☐ Retired ☐ Seasonal worker ☐ Student ☐ Unemployed
☐ Primary care- taker of children and/or home ☐ Other (specify):_____

Highest level of education completed?

What level of literacy is the applicant at? ☐ Low ☐ Medium ☐ High

Does the applicant require any reading supports? ☐ Yes ☐ No	Does the applicant require any writing supports? ☐ Yes ☐ No

If yes to either or both of the above, please explain what additional supports would be required to support the applicant:

Section 6: Legal

Does the applicant have a history with the legal system? ☐ Yes ☐ No
If yes, please complete this section in full. If no, please move to next section.

Does the applicant have any previous convictions/charges/legal involvement? ☐ Yes ☐ No
If yes, describe:

If yes, were charges (*select all that apply*):
☐ Violent ☐ Sexual ☐ Drug-related ☐ Involved a minor ☐ Involved a partner

Does the applicant have any current and/or pending legal orders or legal involvement? ☐ Yes ☐ No
If yes, describe:

If yes, were charges (*select all that apply*):
☐ Violent ☐ Sexual ☐ Drug-related ☐ Involved a minor ☐ Involved a partner

List any upcoming or pending court dates:

Is the applicant currently:
☐ On Parole ☐ Serving a Probation Order ☐ Bound by Release Order/Undertaking (Bail Order)
If you selected any of the above, any applicable documents and orders must be attached.

If yes to either of the above, please provide the following information and include the Parole/Probation/Bail Officer in *Section 2: Consent for Release of Treatment Information*:

Parole/Probation/Bail Officer Name	P/P/B Officer Telephone	P/P/B Officer Email
Address	City, Province	Postal Code

Section 7: Family and Living Arrangements

Note: if the applicant is applying to family program at Kackaamin and/or Nengayni Wellness Centre, please visit their websites for the applicable applications for dependents and families.

Total number of dependent children: _____	Have children been living with their parent(s)? ☐ Yes ☐ No *If no, who do they live with?*

Have Children been apprehended, placed in foster care, or with a Designated Aboriginal Agency? ☐ Yes ☐ No
If yes, specify by which organization or agency:

Does the family have any type of supervision order from a family protection agency? ☐ Yes ☐ No

Does the applicant have any outstanding child custody issues? ☐ Yes ☐ No

Does the applicant have a no-contact order with his/her partner ☐ Yes ☐ No

What is the applicant's current living arrangements?
☐ With my family ☐ With extended family ☐ With parent(s) ☐ With friend(s) ☐ As part of a couple As
☐ a single parent ☐ With partner and kid(s) ☐ Alone ☐ Recovery Home ☐ Homeless ☐ Shelter Other
☐ (specify): _____

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Section 8: Wellness

What is the applicant's sobriety date? _____

Has the applicant ever disclosed harming anyone in a sexually abusive manner or displayed sexually inappropriate behaviour? ☐ Yes ☐ No

Have you been impacted by systemic, trauma-related histories and/or experiences (e.g., Indian Residential School, Day School, extended hospitalization, 60s Scoop, foster care, intergenerational survivor etc.)?

☐ Yes ☐ No *If yes, and you feel safe to do so, please provide further information:*

8.1: Mental

Does the applicant have a history of or have they ever been diagnosed with a mental health condition, disability or challenge by a medical professional? ☐ Yes ☐ No

If yes, please attach assessment if available and select all that apply:

☐ Depression ☐ Anxiety/Panic Disorders ☐ Brain/Head Injury ☐ ADD/ADHD ☐ FAS/FAE PTSD

☐ Military/First Responder PTSD ☐ Other: _____

Does the applicant have a history of: ☐ Suicidal Ideation Self-Harm

Has the applicant ever attempted suicide? ☐ Yes ☐ No If yes, when was last attempt? _____

Has the applicant ever been under a Doctor's care due to mental health condition, disability or challenge?

☐ Yes ☐ No

8.2: Physical

Does the applicant have any chronic or acute medical issues that could affect their participation in the program? ☐ Yes ☐ No

Does the applicant have any ability challenges that the treatment centre should be aware of (e.g. visual impairments, hearing aids, mobility, etc.)? ☐ Yes ☐ No

If yes, please describe what ability support the applicant would require:

8.3: Spiritual

Please share any spiritual or cultural involvement that the applicant takes part in or would like to explore in their healing journey:

Is the applicant willing to respect First Nations healing practices and incorporate spirituality into their healing (e.g. Sweat Lodge, Cedar Brushing, Pipe Ceremony, Smudge, etc.)? ☐ Yes ☐ No

Section 9: Substance Use History

Please circle primary drug(s) of choice

Drug Type	Est. Age of First Use	How Often (rarely, occasionally, monthly, weekly, daily)	Amount/Quantity Used	Date of Last Use
Alcohol				
Amphetamine				
Cannabis				
Cannabis - Medical				
Crystal Meth				
Crack Cocaine / Cocaine Powder				
Hallucinogens				

Heroin				
Inhalants				
Opiates				
Opioid Agonist Therapy				
Prescription Drugs				
Tobacco				
Vaping				
Process addiction (e.g. gambling, eating):				
Other (specify):				
Other (specify):				

Note the following Sections (10 to 13) are to be completed by a medical professional
(E.g. Physician, Nurse Practitioner, Registered Nurse)
Referral workers please ensure this is complete and continue to Appendices if applicable.

Section 10: Treatment History

Has the applicant attended inpatient substance use treatment before? Yes No
If yes, please fill in the following:

Name of previous treatment centre(s)	Dates	Did he/she complete program?
		Yes No
		Yes No
		Yes No

Has the applicant participated in outpatient or community-based healing programs? Yes No
If yes, please explain:

Section 11: Additional Information

In case of early dismissal or incompletion of the program, does the applicant have a plan in place?
Yes No
If yes, please share with Centre, if no please work with the applicant to establish one.

Beyond the scope of this application, do you have any additional comments or information that the intake staff should be aware of?

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Section 12: Medical Assessment

Must be completed by medical personnel (e.g., Physician, Nurse Practitioner, Registered Nurse)

Date of Assessment/Referral:	Are you the applicant's regular Physician/Nurse? ☐ Yes ☐ No
Applicant's Name:	Date of Birth (DD/MM/YYY):
Personal Health Care Number:	Status Number (if applicable):

I,_____(applicant's name), hereby request and authorize

(Physician, Nurse Practitioner or Registered Nurse's name) to release medical information pertaining to myself to the identified First Nations Health Authority Funded Treatment Centres (under *Section 1*) and to the Referral Agent acting on my behalf.

_____
Applicant's Signature Date

_____
Medical Personnel's Position/Title

_____
Medical Personnel's Signature Date

Informed consent must be completed with the Patient.
Note: This form is applicable for one year after signed and dated. The Applicant may change or revoke this release at any time by giving notice to the Treatment Centre in writing.

Specify any dietary requirements (allergies, intolerances, diabetes, etc.):

Current medications (Names)	Dose (ml/mg)	Reason for taking	How long has applicant been taking?	Prescriber	Has refills?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Is applicant currently on Opioid Agonist Therapy (OAT)? ☐ Yes ☐ No
If yes, please complete the following information.

OAT Prescribing Physician/Nurse Practitioner:
Name Telephone Fax

Address City, Province Postal Code

Specify Replacement Type (e.g. Methadone, Suboxone, etc.):	Initial dose (mg) Current dose (mg)
Length of OAT:	Length of time on current dose:

Note: If you are applying to Round Lake Treatment Centre, please refer to and complete *Methadone & Suboxone Program Contract*

Have you reviewed the prescribed medication with the applicant? ☐ Yes ☐ No
Is the applicant taking their medication as prescribed? ☐ Yes ☐ No

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Medical History	Comments
Does the applicant have any communicable diseases? ☐ Yes ☐ No	
Does the applicant have any head trauma or cognitive impairment? ☐ Yes ☐ No	
Does the applicant have a history of seizures? ☐ Yes ☐ No	
Does the applicant have any chronic illnesses or conditions? ☐ Yes ☐ No	
Does the applicant have any cardiovascular disorders or conditions? ☐ Yes ☐ No	
Does the applicant have any allergies? ☐ Yes ☐ No	Does applicant require an Epi-Pen or Ana-Kit? ☐ Yes ☐ No ***Note: Applicant is required to supply their own Epi-Pen or Ana-Kit***
Is the applicant pregnant? ☐ Yes ☐ No ☐ N/A	If yes, how many weeks? _____

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Section 13 to be completed by a medical practitioner (Physician, Nurse Practitioner, RN/LPN)

Section 13: Tuberculosis (TB) Screening (if entering in Panorama, refer to Panorama entry guides)		
The purpose of TB screening for entry into treatment programs is to **rule out active TB**. **TB skin testing (TST) is not required**, and should never delay program entry, but would be of benefit to the client later. **A chest x-ray (CXR) is also not required for entry into a treatment center**. A CXR would only be ordered by the medical practitioner if further investigation is required. People who use substances are an important group to consider for regular TB screening and this screening continues to be an essential part of TB prevention and overall wellness.		
A. TB Symptom Assessment		
☐None	☐Fever	☐Short of Breath
☐Chest Pain	☐Haemoptysis	☐Sputum Production
☐Cough (for >3weeks)	☐Lymphadenopathy	☐Unintentional Weight Loss
☐Fatigue	☐Drenching Night Sweats	☐Other:
*** If client has a cough, or other symptoms consistent with active TB, collect 3 sputum for AFB, send client for CXR, and complete TB Screening Form (see link at end of this section) for review by TB Services prior to program entry. *** For clients who live in a First Nations community fax form to FNHA TB Services at 604-689-3302. For clients who reside within VIHA fax to Island TB Services at 250-519-1505. For all other clients fax form to BCCDC at 604-707-2690.		

B. TB History (check all that apply)	
☐ Has the client ever had a positive TST and/or IGRA result?	
☐ Has the client ever been in contact with someone with active TB?	
☐ Has the client ever been treated for TB?	
***If TB history is unclear, please contact FNHA TB Services at 1-844-364-2232**. FNHA Clinical Nurse Advisors can provide practitioners with the client's TB history.	
C. TB Risk Factors	
Certain risk factors pose a higher risk for progression to active TB in the presence of TB infection or increase the risk of exposure to TB (check all that apply):	
☐ None	☐ Substance Use (alcohol or other)
☐ HIV	☐ Tobacco Use
☐ Transplant (Specify):	☐ Work or live in a congregate setting (past or current)
☐ Diabetes ☐ Chronic Kidney Disease/Dialysis	☐ Work or live in a Correctional Facility (past or current)
☐ Cancer (Specify):	☐ Homelessness/Underhoused (past or current)
☐ Immune Suppressing Meds (name, dose & duration):	

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

***Health Practitioners only need to submit this Page 2 Section D to treatment center intake for clearance.**

D. Client Consent and Clearance
If client lives in a First Nations community, please discuss sharing this information with FNHA TB Services for follow-up purposes in community. If client lives off-reserve/not in community, it is not required to send this form to FNHA TB Services.
☐I, _____, consent to sharing the above information with FNHA TB Services. (print name) Client's Signature: _____ Date: _____ Client's Date of Birth:_____ **If consent provided, please fax these 2 pages (i.e. Section 13 only) to FNHA TB Services at 604-689-3302.** ☐ **Check this box: This person has undergone TB screening and has no symptoms of active TB and is cleared for entry into treatment center.** Health Practitioner Signature: _____ Date: _____ Print Name: _____ Clinic Name: _____

***Link to BCCDC TB Screening Form if client is symptomatic, receiving a TB skin test (TST) and requiring further follow up.**

TB Screening Form

http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/TB/CPS_TB_ScreeningForm.pdf

TB Screening Form Guidance Document

http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/TB/Documentation_Guide_TBScreeningForm.pdf

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Section 14: Tsow Tun Le Lum - Additional Medical Questions
Only to be completed by those applying to attend treatment at Tsow Tun Le Lum (*Section 1*)
Does the applicant take prescribed narcotic/opioid medication? ☐ Yes ☐ No *If yes, please specify:* _____
Is the applicant currently receiving specialized medical care? (e.g., injections, dialysis, physiotherapy, Chiropractor, etc.) ☐ Yes ☐ No

Referral Agent Contact Information:

*Name:*_____

Email Address: _____

Fax #: _____

Important Notice for Medical Professional:

Once the Medical Assessment is complete, please provide the **completed pages** (pages 10 to 13) to both the Referral Agent acting on the applicants behalf (contact information below), as well as directly to the applicant.

Applicant Name: _____
Date of Birth (DD/MM/YY): _____

Appendix A

To be completed by a referral worker in collaboration with the applicant.
Note: Only to be completed by applicants to: Tsow Tun Le Lum Program, Round Lake Treatment Centre Program, Kackaamin Family Development Centre, North Wind Wellness Centre, and Gya'Wa'Tlaab Healing Centre

Counsellor's Perspective

What is important that you need us to know about this applicant?

What is your perception of the applicant's readiness for treatment?

Has the applicant ever been violent with their partner or children? ☐ Yes ☐ No

Is the applicant willing to share about their past in a group setting? ☐ Yes ☐ No

IN CASE OF EARLY DISCHARGE:

If travel arrangements are not pre-scheduled, can the Centre be reimbursed for Applicant's travel expenses?

☐ Hotel ☐ Food ☐ Transportation

Who will make the reimbursement?

Presenting Problems

Please have the applicant write the answers to the following question or offer them the necessary support to respond.

Why do you want to come to Treatment? Why now?

What do you believe is the treatment centre's role in your overall treatment plan?

What are Your:

Strengths (assets, resources):

Needs (liabilities, weaknesses):

Abilities (skills, aptitudes, capabilities, talents, competencies):

Preferences (those things the applicant thinks or feels will enhance their treatment experience):

Presenting Problems and Challenges:

Check All Applicable Boxes:

☐ Trauma (PTSD) ☐ Anxiety/Panic Disorder ☐ Anger/Acting Out ☐ Grief & Loss ☐ Sexual Harm/Abuse
☐ Foster Home Care ☐ Family Violence (Assaults/Battery/Trauma)
☐ Family Trauma (child apprehension, custody problems, lateral violence, marriage problems/breakdown, etc.)

Medical and Mental Health Report

If a mental health diagnosis/challenge was identified in Section 8.1, please separately provide more information including whether applicant still in treatment with doctor/psychologist, Name of doctor who provided diagnosis, and if so a written summary of the applicant's therapy plan, how long the applicant has been mentally stable, current cognitive status and whether the applicant Is able to participate in group therapy for up to eight hours and is willing to share about their past in a group setting? (please attach further information)