

# Treatment Centre Adult Referral Application Package



First Nations Health Authority  
Health through wellness

June 2025

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

## Inclusion Criteria

INCLUSION	Carrier Sekani Family Services	Gya' Wa' Tlaab Healing Centre	Kackaamin	' Namgis Treatment Centre	Nenqayni Wellness Centre	North Wind Wellness Centre	Round Lake Treatment Centre	Tsow-Tun Le Lum Society	Wilp Si' Satxw House of Purification
Opioid Replacement Therapy	✓	✓			✓	✓	✓		✓
Family Program			✓		✓				✓
Couples Program			✓						✓
Pregnant	✓				✓	✓	✓	✓	✓
Co-ed	✓		✓			✓	✓	✓	✓
Men-only sessions		✓	✓	✓					✓
Women-only sessions			✓	✓					✓
Youth-only sessions					✓ <sup>1</sup>				✓
Corrections Program						✓		✓	✓
Barrier Free (person with ability challenges)			✓				✓	✓	✓
Alcohol-free	No	Minor with-drawal	3 Weeks	14 Days	14 Days	14 Days	14 Days	14 Days	14 Days
Other Substance-free	No	Minor with-drawal	3 Weeks	14 Days	14 Days	14 Days	14 Days <sup>2</sup>	14 Days	14 Days
Requires signed Rules and Regulations with Application <sup>3</sup>						✓			

<sup>1</sup> Female-Youth Only

<sup>2</sup> Note: RLTC requires applicants to be 5 months free of Crystal Meth in order to attend their programs

<sup>3</sup> Please visit their website to review and complete *Rules and Regulations* with applicant and submit to Centre

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## Treatment Centre Descriptions

 <p>CARRIER SEKANI FAMILY SERVICES</p>	<p><b>Carrier Sekani Family Services</b>          P.O. Box 1219          Vanderhoof, B.C.          V0G 2A0  <a href="https://www.csfs.org/services/addiction-recovery-program">https://www.csfs.org/services/addiction-recovery-program</a>          Telephone: (250) 567-2900          Toll-free: 1-866-567-2333          Fax: (250) 567-2975</p>	<p>Length: 6-week          Medical Withdrawal/Detox: Yes          OAT: Yes          Family Program: No          Couples Program: No          Gender: Co-ed          Pregnant: Yes (2nd Tri.)          Substance free: Not required</p> <p><b>Residential Treatment Program only April - October</b></p>
	<p><b>Gya'Wa'Tlaab Healing Centre</b>          P.O. Box 1018          Haisla, B.C.          V0T 2B0  <a href="https://www.gyawatlaab.ca/">https://www.gyawatlaab.ca/</a>          Telephone: (250) 639-9817          Fax: (250) 639-9815</p>	<p>Length: 6/7/8-week          OAT: Yes          Family Program: No          Couples Program: No          Gender: Men-only          Pregnant: N/A          Substance Free: Minor Withdrawal</p>
	<p><b>Kackaamin</b>          7830 Beaver Creek Road          Port Alberni, B.C.          V9Y 8N3  <a href="https://www.kackaamin.org/">https://www.kackaamin.org/</a>          Telephone: (250) 723-7789          Fax : (250) 723-5067</p>	<p>Length: 6-week          OAT: No          Family Program: Yes          Couples Program: Yes          Gender: Co-ed, Men- &amp; Women-only          Pregnant: No          Substance Free: 3 weeks</p> <p><b>See website for children and youth applications</b></p>
	<p><b>'Namgis Treatment Centre</b>          P.O. Box 290          Alert Bay, B.C.          V0N 1A0  <a href="http://www.namgis.bc.ca/health-services/treatment-centre/">http://www.namgis.bc.ca/health-services/treatment-centre/</a>          Telephone: (250) 974-5522          Fax: (250) 974-2257</p>	<p>Length: 6-week          OAT: No          Family Program: No          Couples Program: No          Gender: Women- &amp; Men-only          Pregnant: No          Substance Free: 14 days</p>
	<p><b>Nenqayni Wellness Centre</b>          P.O. Box 2529          Williams Lake, B.C.          V2G 4P2  <a href="https://nenqayni.com/">https://nenqayni.com/</a>          Telephone: (250) 989-0301          Fax: (250) 989-0307</p>	<p>Length: 7/8-week          OAT: Yes          Family Program: Yes          Couples Program: Yes, with children          Gender: Couples with Children          Pregnant: Yes          Substance Free: 14 days</p> <p><b>See website for children and youth applications</b></p>

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



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## 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 [Nengayni 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*)

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## 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: _____	<input type="checkbox"/> Pre-Treatment Information <input type="checkbox"/> Attendance Verification <input type="checkbox"/> Progress during Treatment <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Final Discharge Report
Individual #2 E.g. Probation Officer	Organization	Phone: _____ Email: _____ Fax: _____	<input type="checkbox"/> Pre-Treatment Information <input type="checkbox"/> Attendance Verification <input type="checkbox"/> Progress during Treatment <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Final Discharge Report
Emergency Contact	Relationship to Applicant	Phone: _____ Email: _____ Fax: _____	<input type="checkbox"/> Attendance Verification <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Emergency Situation <input type="checkbox"/> Can be contacted after hours
Emergency Contact	Relationship to Applicant	Phone: _____ Email: _____ Fax: _____	<input type="checkbox"/> Attendance Verification <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Emergency Situation <input type="checkbox"/> 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.**

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### 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there supportive services available to applicant upon discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the applicant completed pre-treatment and/or healing sessions (e.g., AA, NA, Counselling, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain what type of support and how many sessions have been completed:</i>		
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	
<input type="checkbox"/> On Reserve <input type="checkbox"/> Off Reserve	Email:		
Self-Identified Gender (select all that apply): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Questioning <input type="checkbox"/> My Gender is _____ Preferred Pronoun: <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They <input type="checkbox"/> My Pronoun is: _____ <i>If you identify as transgender, non-binary, or Two-Spirit, please inform us what residential space the applicant would prefer to stay within: <input type="checkbox"/> Male <input type="checkbox"/> Female</i>			
Indigenous Identity: <input type="checkbox"/> Status <input type="checkbox"/> Non-Status <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/> N/A			
Status Number (if applicable)	Band Name (if applicable)	Treaty Community (if applicable)	
Personal Health Number	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Common-Law <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Has applicant been mandated to attend treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom? _____ <i>Must attach any applicable documents</i>			

#### 4.2 Funding Resources

Have funding options been explored? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Note: Funding resources must be in place prior to attending</b> If yes, provide details (e.g. Corrections, Employer, FNHA, self, Band, etc.):
Does the applicant have funding for travel to and from treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have travel arrangements been arranged? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Section 5: Income and Education

Source of income (employed, social assistance, disability, etc.)?
Current occupation: <input type="checkbox"/> Employed full- time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal worker <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Primary care- taker of children and/or home <input type="checkbox"/> Other (specify): _____

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Highest level of education completed?		
What level of literacy is the applicant at? <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High		
Does the applicant require any reading supports? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the applicant require any writing supports? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to either or both of the above, please explain what additional supports would be required to support the applicant:		
<b>Section 6: Legal</b>		
Does the applicant have a history with the legal system? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete this section in full. If no, please move to next section.</i>		
Does the applicant have any previous convictions/charges/legal involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:		
If yes, were charges (select all that apply): <input type="checkbox"/> Violent <input type="checkbox"/> Sexual <input type="checkbox"/> Drug-related <input type="checkbox"/> Involved a minor <input type="checkbox"/> Involved a partner		
Does the applicant have any current and/or pending legal orders or legal involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:		
If yes, were charges (select all that apply): <input type="checkbox"/> Violent <input type="checkbox"/> Sexual <input type="checkbox"/> Drug-related <input type="checkbox"/> Involved a minor <input type="checkbox"/> Involved a partner		
List any upcoming or pending court dates:		
Is the applicant currently: <input type="checkbox"/> On Parole <input type="checkbox"/> Serving a Probation Order <input type="checkbox"/> Bound by Release Order/Undertaking (Bail Order) <i>If you selected any of the above, any applicable documents and orders must be attached.</i>		
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
<b>Section 7: Family and Living Arrangements</b>		
<i>Note: if the applicant is applying to family program at <a href="#">Kackaamin</a> and/or <a href="#">Nengayni Wellness Centre</a>, please visit their websites for the applicable applications for dependents and families.</i>		
Total number of dependent children: _____	Have children been living with their parent(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who do they live with?	
Have Children been apprehended, placed in foster care, or with a Designated Aboriginal Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify by which organization or agency:		
Does the family have any type of supervision order from a family protection agency? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the applicant have any outstanding child custody issues? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the applicant have a no-contact order with his/her partner <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is the applicant's current living arrangements? <input type="checkbox"/> With my family <input type="checkbox"/> With extended family <input type="checkbox"/> With parent(s) <input type="checkbox"/> With friend(s) <input type="checkbox"/> As part of a couple As <input type="checkbox"/> a single parent <input type="checkbox"/> With partner and kid(s) <input type="checkbox"/> Alone <input type="checkbox"/> Recovery Home <input type="checkbox"/> Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Other <input type="checkbox"/> (specify): _____		



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## 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				

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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?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> 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?

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## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Applicant's Name:	Date of Birth (DD/MM/YYYY):
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?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> 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

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

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**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**

<input type="checkbox"/> None	<input type="checkbox"/> Fever	<input type="checkbox"/> Short of Breath
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Haemoptysis	<input type="checkbox"/> Sputum Production
<input type="checkbox"/> Cough (for >3weeks)	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Unintentional Weight Loss
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Drenching Night Sweats	<input type="checkbox"/> 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):

<input type="checkbox"/> None	<input type="checkbox"/> Substance Use (alcohol or other)
<input type="checkbox"/> HIV	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Transplant (Specify):	<input type="checkbox"/> Work or live in a congregate setting (past or current)
<input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic Kidney Disease/Dialysis	<input type="checkbox"/> Work or live in a Correctional Facility (past or current)
<input type="checkbox"/> Cancer (Specify):	<input type="checkbox"/> Homelessness/Underhoused (past or current)
<input type="checkbox"/> 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	
<p>If client lives in a First Nations community, please discuss sharing this information with FNHA TB Services for follow-up purposes in community.</p> <p>If client lives off-reserve/not in community, it is not required to send this form to FNHA TB Services.</p>	
<p><input type="checkbox"/> I, _____, consent to sharing the above information with FNHA TB Services. (print name)</p>	
Client's Signature: _____	Date: _____
Client's Date of Birth: _____	
<p><b>If consent provided, please fax these 2 pages (i.e. Section 13 only) to FNHA TB Services at 604-689-3302.</b></p>	
<p><input type="checkbox"/> Check this box: This person has undergone TB screening and has no symptoms of active TB and is cleared for entry into treatment center.</p>	
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](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](http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/TB/Documentation_Guide_TBScreeningForm.pdf)

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

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