Clear Hills Youth Treatment Centre

INTAKE/REFERRAL APPLICATION

Medical Assessment

We Thank Creator

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED.
INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS. Form to be completed by referring agent.
If any information is not applicable indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

CHYTC INTAKE/REFERRAL APPLICATION

Client Information				
Date Application Received by Community Worker:		Date Application Received by Treatment Centre:		
Surname:	First Name:		Nickname or other name known by:	
Date of Birth:	Age:	Sex:	Provincial Health Card Number:	
Client Address:		Gender: ☐ Female/Woman ☐ Male/Man ☐ Transgender ☐ Intersex ☐ Two-Spirited ☐ Gender Fluid ☐ No category describes me ☐ Unknown ☐ Decline to state		Client Phone:
Language Spoken:	Language Preferred:		Language Understood:	
Status Indian:	Treaty Number:		Band Name:	
Biological Parents:				
Guardian Name:		Guardian Address:		Guardian Phone:
Place of Employment:			Phone:	
Living Situation:	☐ On-reserve ☐ Off-reserve ☐ Urban ☐ Rural ☐ Immediate Family ☐ Extended Family ☐ Lives Alone ☐ Homeless ☐ Group Home ☐ Shelter ☐ Foster Care ☐ Common Law ☐ Friend			

Social Services Involvement			
Agency Name:		Phone:	

Worker Name:		Client Status:	☐ Crown Ward ☐ Society Ward ☐ Voluntary Placement ☐ VPA ☐ Other
Child welfare involvement:	☐ Yes ☐ No ☐ Unknown		

Family/Relationships	
Does client have dependant children?	☐ Yes ☐ No
If yes, do they have access to adequate childcare while in treatment?	☐ Yes ☐ No
Are the children in care?	☐ Yes ☐ No
Does the client have other dependants?	☐ Yes ☐ No
Provide information on client's children or other dependants:	

Name	Age	Relationship

Who does your client live with?	☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care	Who does your client feel closest to?	
How does your client get along with his/her family members?	☐ Not Good ☐ Fair ☐ Good ☐ Excellent		
Does client have any siblings?	☐ Yes ☐ No		
Name	Age	Health Status	Lives With
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only

			☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
			☐ Mom Only ☐ Dad Only ☐ Mom and Dad ☐ Alone ☐ Friends ☐ Siblings ☐ Extended Family Members ☐ Foster Care
Maternal			
Paternal			

Does your client have any close friends?	☐ Yes ☐ No	If so, who?	
Does he/she have a girlfriend or boyfriend?	☐ Yes ☐ No	Is he/she sexually active?	☐ Yes ☐ No
Does he/she talk to any elders?	☐ Yes ☐ No	Is he/she willing to listen?	☐ Yes ☐ No
Religious Beliefs	☐ Traditional ☐ Roman Catholic ☐ Protestant ☐ Other		
Other			
Family Supports:			
Family Strengths:			

Education

Does your client go to school?	☐ Yes ☐ No ☐ Unknown	Does your client like school?	☐ Yes ☐ No
Highest grade completed?	☐ Less than grade 8 ☐ Completed high school ☐ Not completed high school ☐ Completed post-secondary ☐ Some post-secondary		
Name of school:		Last year attending this school	

Medical History

Does your client have any medical problems?	☐ Yes ☐ No	Does he/she require a medical consent form?	☐ Yes ☐ No
Please identify:			
Family doctor's name and phone number:			
Is your client currently on any medication?	☐ Yes ☐ No	Does he/she have any allergies?	☐ Yes ☐ No

Legal Problems

Has your client ever been in trouble with the law?			☐ Yes ☐ No ☐ Unknown
Please explain:			
Legal System Involvement:	☐ Criminal Court ☐ Family Court ☐ Drug Court Treatment ☐ Probation ☐ Charges Pending ☐ Court Referral ☐ Court Order ☐ Restorative Justice	Gang Involvement:	☐ Yes ☐ No ☐ Unknown

	☐ No Involvement ☐ Unknown		

Was alcohol or any other substances; such as `sniff` or drugs involved during your client`s legal problems?	☐ Yes ☐ No
Please explain:	
Is your client currently on probation or on a court order?	☐ Yes ☐ No

Name of probation officer:		Phone:		Fax Number:	
Probation Order	From:		To:		
Conditions:					
Copy Attached?	☐ Yes ☐ No	Has your client been involved with any Solvents/Substance Abuse?	☐ Yes ☐ No		

Chemical Use History

At what age did your client start sniffing?		At what age did your client start alcohol?	
At what age did your client start using other drugs?		Does anyone else in his/her family use solvents/substances?	☐ Yes ☐ No
If so, who else?			
Does he/she use solvents/substances with others or by him/her self?	☐ With others ☐ Alone ☐ Always alone ☐ Always with others ☐ Mostly alone ☐ Mostly with others ☐ Alone and with others	Does your client usually sniff or huff at home?	☐ Yes ☐ No
Does your client usually sniff or huff at a friend's house?	☐ Yes ☐ No	Does your client usually sniff or huff at school?	☐ Yes ☐ No
Does your client usually sniff or huff in an abandoned building?	☐ Yes ☐ No	Does your client usually sniff or huff in an abandoned car or truck?	☐ Yes ☐ No
Does your client usually sniff or huff at a party?	☐ Yes ☐ No	Does your client usually sniff or huff outdoors?	☐ Yes ☐ No
Is there any other place your client usually sniffs or huffs?			
Has your client ever lost friends because of sniffing or huffing?	☐ Yes ☐ No	Has your client ever gotten into any physical fights when using?	☐ Yes ☐ No
Has your client ever caused serious injury to other?	☐ Yes		

	☐ No

Please explain:	
Does the client have any medical, physical, psychological, emotional problems because of the use of solvents/substances?	☐ Yes ☐ No
Please explain:	
Does he/she feel that they have control over their use of solvents/substances?	☐ Yes ☐ No
Has he/she ever considered reducing or quitting?	☐ Yes ☐ No
Has he/she ever been in any previous treatment for their use of solvents/substances?	☐ Yes ☐ No ☐ Unknown
Where have they had previous treatment?	

	When have they had previous treatment?	

How long did the client stay in the program? (in months)	
Has client participated in a non-residential/community based substance abuse and/or mental health program?	☐ Yes ☐ No
If yes, what type of program(s):	

Psychological Functioning

Has your client ever spoken or written about killing him/her self?	☐ Yes ☐ No ☐ Unknown	Has your client ever attempted to kill him/her self?	☐ Yes ☐ No ☐ Unknown
How many times?			
How did he/she attempt to kill him/her self?			
Has the client frequently gone off on their own when he/she is depressed or unhappy?	☐ Yes ☐ No	Is the client sad/unhappy?	☐ Yes ☐ No
How often is the client sad/unhappy?	☐ None of the time ☐ Some of the time ☐ Most of the time ☐ All of the time	Self-harming behavior(s):	☐ Yes ☐ No ☐ Unknown
Is there any known history of sexual abuse?	☐ Yes ☐ No ☐ Unknown	Is there any known history of physical abuse?	☐ Yes ☐ No ☐ Unknown
Is there any known history of emotional abuse?	☐ Yes ☐ No		

Please explain: (i.e. at what age, has it been reported and what is the outcome or current status)	
Is there any history of family violence that this child may have been witness to?	☐ Yes ☐ No

	☐ Unknown
Please explain:	
When the client is in a sober state has he/she communicated with spirits that no one else can see or hear?	☐ None of the time ☐ Some of the time ☐ Most of the time ☐ All of the time
Are these communications positive or negative experiences for the client?	☐ Positive ☐ Negative ☐ Indifferent
Please explain:	
Are there times when people are unable to communicate with the client?	☐ None of the time ☐ Some of the time ☐ Most of the time ☐ All of the time
Please explain:	
Has your client ever had any psychological testing or counseling?	☐ Yes ☐ No
If so, for what purpose?	

Self-harming Behaviour(s):	☐ Yes ☐ No ☐ Unknown
Outside Resources	
Are there any other agencies involved with your client and his/her family?	☐ Yes ☐ No
If so, which ones and what services do they provide? (for example, NNADAP, CHR, CFS)	
Family Activities/Practices: (What do you see as a family?)	
Family Roles/Relationships: (How do they interact with each other?)	
Status in the Community: (How is the family perceived in the community?)	
What type of belief system is practiced?	
How does he/she spend his/her leisure time?	
Who are the other support people involved with the family? (example; elders, extended family, community groups, community workers, CHR, NNADAP, CWPW)	
Is the client aware of the effects of solvents/substances?	☐ Yes ☐ No
Is the client's family aware of the effects of solvents/substances?	☐ Yes ☐ No

Is the client's community worker aware of the effects of solvents/substances?	☐ Yes ☐ No
Does the family believe the client recognizes that he/she has a problem?	☐ Yes ☐ No
What steps does the family want to take to address the problem?	
Has anyone in his/her family or community received treatment for solvent/substance abuse?	☐ Yes ☐ No ☐ Unknown
Please explain:	
Are the parent(s) supportive of their child receiving treatment? (refer to Referral Agent Agreement and Parental Consent Form)	☐ Yes ☐ No
Please explain:	
Upon the child's completion of the program, what type of support system do you see as effective/useful to help maintain a clean lifestyle for self/child?	
Are the extended family members supportive of the family seeking help and/or treatment for themselves or their child?	☐ Yes ☐ No
Please explain:	
Would the family be willing to come to our Treatment Centre to observe the program in action as part of the intake process?	☐ Yes ☐ No

PART 3 – MEDICAL ASSESSMENT

Applicant's name:		Health Care Number:	
Treaty Number (10 digits)		Are you the client's regular physician?	☐ Yes ☐ No

A. Medical History: (explain any 'yes' responses in Section B)

	Diagnosed		Tested		Comments
	Yes	**No**	**Yes**	**No**	
Central Nervous System Disorder	☐	☐	☐	☐	
Chronic bronchitis	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Heart problems	☐	☐	☐	☐	
Gastrointestinal problems	☐	☐	☐	☐	
Pancreatic problems	☐	☐	☐	☐	
Kidney or urinary problems	☐	☐	☐	☐	
Diabetes / hypoglycemia	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
Chronic pain	☐	☐	☐	☐	
Eating disorders	☐	☐	☐	☐	
Sleep disorders	☐	☐	☐	☐	
Withdrawal symptoms, seizures, etc.	☐	☐	☐	☐	
Mood disorders (e.g., major depressive disorder)	☐	☐	☐	☐	
Psychotic disorders (e.g., schizophrenia)	☐	☐	☐	☐	
Personality Disorders	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	
Liver problems: Hepatitis B & C	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
Sexually Transmitted Infections	☐	☐	☐	☐	
Medical confirmation of pregnancy	☐	☐	☐	☐	# weeks
Is all related testing complete? ☐ Yes ☐ No	If no, please describe				
Are there any special considerations regarding the pregnancy and pre-natal care we need to be aware of?					
Current blood pressure:					
Doctors Signature:					Date:
Clinic where assessment was completed:					