Whiskyjack Treatment Centre Inc.
Family Treatment Referral

Whiskyjack Treatment Centre Inc.

P.O. Box 580, Norway House, MB R0B 1B0

Phone (204) 359-8995 Fax (204) 359-6497

Practice Model - Programs and Services

Policy Statement

The Whiskyjack Treatment Centre provides effective holistic healing within a safe environment of respect, trust and love through consistent teamwork, unique services and traditional values.

The programs and services of the Whiskyjack Treatment Centre are designed to meet the best interests of the clients. The WTC provides a sheltered environment for the delivery of programs and services oriented towards personal and cultural enhancement and development.

Clients are encouraged to participate in all the programs and activities offered by WTC.

The programs and services are as follows:

- Clinical Services
- Counselling/Debriefing Services
- Cultural and Traditional Teachings
- Educational Sessions
- Family Program
- Personal Development Program
- Job Readiness/Application/Resume Writing
- Land Base Program
- Language Awareness
- Personal Life Management
- Healthy Choices & Recreational Projects
- Parenting Strategies
- Substance Abuse Program

WTC Family Services Intake Form

This form is to be completed in full.

Date of Referral: _____Organization: _____
Name of Referral Worker: _____Position: _____
Address: _____Postal Code: _____
Phone #: _____Cell: _____Fax #: _____

Referral Information:

Adult: 1_____
Date of Birth: _____Present Age: _____Male: _____Female: _____
Medical #: _____ PHIN #: _____Province of Registration: _____
Band Name and Number (10 digit): _____
Social Insurance Number (If available): _____
Treaty Number: _____
Client's Address: _____
Languages Spoken: English _____ Cree _____ Other _____
Languages Understood: English _____ Cree _____ Other _____

Adult: 2 _____
Date of Birth: _____Present Age: _____ Male: _____ Female: _____
Medical #: _____ PHIN #: _____Province of Registration: _____
Band Name and Number (10 digit): _____
Social Insurance Number (If available): _____
Treaty Number: _____
Client's Address: _____
Languages Spoken: English _____ Cree _____ Other _____
Languages Understood: English _____ Cree _____ Other _____

Emergency contact number: _____

Please list all dependant children attending with family;

Name	Date of Birth,	Age	Gender	Treaty Numbers	Medical Numbers	PHIN Numbers

(Please list all dependent children **NOT** attending with the family, (including customary, step and foster)

Name	Age	Gender	Date of Birth	Lives with/In care of

(Please list all who are considered significant others by the family)

Name	Relationship

Please indicate if the family is involved with any Child Care Protection Agency.

Voluntary Placement Agreement _____
Date of VPA ordered and date of discharge_____

Temporary Order _____
Date TOG granted and discharge date _____

Permanent _____
Date Permanent Order granted_____

Please include Social History with the child(ren) that will be attending the Whiskyjack Treatment Centre Family Program if the child(ren) that are in care.

Medical History:

1. **Medical Condition:**

Name:	Medical Condition:
_____	_____
_____	_____
_____	_____
_____	_____

2. **Prescribed Medication:**

Name:	Medication:
_____	_____
_____	_____
_____	_____

3. **Allergies:**

Name:	Allergies:
_____	_____
_____	_____
_____	_____

4. **Family member diagnosed with FASD, or any medical diagnose?**

Name:	Diagnosis:
_____	_____
_____	_____
_____	_____

Legal History: (If you answer yes please provide documentation)

1. Is any family member involving the legal system? Yes _____No ____
2. Is any family member on Probation? Yes_____No ____
3. Is any family member on a court order or court ordered to attend? Yes _____No

Name of Probation Officer: _____

Phone #: _____Fax #: _____

Probation Order: From _____To _____

Conditions: _____

Please Attached Condition Order: Yes _____No _____

Substance Use:

Substance	Yes	No	How long? Months/Years.	Family Members Name
Alcohol (beer, wine, hard liquor, home brew, etc.)				
Marijuana, Hashish				
Inhalants (glue, paint), sprays, solvents, gas				
Cocaine (e.g. crack, coke)				
Stimulants/Amphetamines				
Opiates-Morphine, heroin, Dilaudid				
Tranquillizers-Ativan, Valium, Librium, Zanax				
Hallucinogen-LSD, PCP, Dust, Mushrooms				
Painkillers-Codeine, Percodan, Alwin				
Crystal Meth				
Tobacco-Other				
Prescription Drugs (e.g. T3's, etc.)				
Over the counter Drugs				
Other				

1. Has the family been in any other treatment for use of solvents/substances?
   Yes _____No _____Who _____Where _____
Completed? Yes_____No_____

Psychological Functioning:

1. Has any family member ever spoke or wrote about suicide? Yes _____No _____
2. Has any family member ever attempted suicide? Yes _____No _____
3. Has any of the family members diagnosed for mental illness? Yes _____No _____
4. Is the family or any family member involved with gangs?
   Please Explain: _____

Family:

1. Family Activities/Practices: (What do you see as a family?)

   _____

   _____

2. Family Roles/Relationships: (How they interact with each other?)

   _____

   _____

3. Status in the community: (How is the family think they're perceived in the community?)

   _____

4. What type of belief system is practised? _____

5. How does the Family spend their leisure time?

   _____

6. Who are the other support people involved with the family? (example, Elders, Extended Family, Community Resources, Community Workers, Community Wellness)

   _____

   _____

7. Is the family aware of the adverse effects of solvents/substances? Yes _____ No_____

8. Does the family recognize that they have a problem?

   _____

9. Are the extended family members supportive of the family seeking help and treatment?

   _____

10. Identify any significant losses or areas that may be affecting the family related to unresolved Grief? _____

_____

Referral Worker's Recommendations:

Indicate what areas of healing or Issues Whiskyjack Treatment Centre should concentrate on?

Provide any additional information that the family feels may contribute to their treatment?

Family's Stage of Readiness

____Pre-contemplation
____Contemplation
____Determination
____Action
____Maintenance

Please submit any relevant documents if required and necessary.

____Psychiatric Evaluations
____Probation and Court Orders
____Pending Court Dates
____Any Assessments
____Any conditions ordered from Child and Family Services Agency

CLIENT CONSENT TO TREATMENT

I, _____, do hereby consent admission to attend the treatment Program at Whiskyjack Treatment Centre.

I agree to cooperate with the following:
_____Medical and Physical Examination
_____Laboratory Testing
_____Prescribed Medical Care
_____Psychological and/or Psychiatric Testing
_____Treatment/ Treatment Plan
_____Family Treatment
_____After Care Plan

I agree and consent to being transported to the appropriate referral agency for specified treatment and testing as may be necessary.

Signature of: _____

Signature of Parent/ Guardian: _____

Signature of Referral Agent: _____

Date: _____

All documents must signed and dated

AUTHORIZATION FOR RELEASE FOR INFORMATION

I, _____, Parent or Legal Guardian of the said

(Name of Parent(s)

Child, _____, do hereby give my permission to release

(Name of child)

The following information:

_____Birth Certificates

_____Medical Records

_____School Records

_____Other Records, as required for Treatment

In respect of: _____

(Name of Child)

_____

(Date of Birth)

_____

(Band and treaty number, if Applicable)

Signature of Parent / Legal Guardian: _____

Signature of Referral Agent: _____

Date: _____

All documents must signed and dated

CLIENT MEDICAL EXAMINATION FORM

Name of client: _____Medical #: _____
Band and Treaty #: _____

Substance Use Information:

Substance	Yes	No	Length use & comment
Inhalants			
Opiates			
Barbiturates			
Marijuana			
Amphetamines			
Alcohol			
Smoking/chewing tobacco			
Non-Prescribe Drugs			

Please check off any of the withdrawal symptoms that the individual may be experiencing. Has the client receive any medical or detoxification prior to entering treatment?

Symptoms	Yes	No	How long?	Any medication prescribed
Blackouts				
Hallucinations				
Nausea/Vomiting				
Seizures				
Shakes				
Delirium Termers DT's				
Ever experienced DT's				

Medical Information:

Physical health/Problems & diseases	Yes	No	Provide Details
Allergies			
Hepatitis A, B, and C			
Diabetes			
Respiratory Conditions			
Heart Conditions			
Tuberculosis			
Physical Disabilities			
STI's/HIV/AIDS			
FASD/Developmental Delays			
Pregnancies			
Other medical information			
Vaccinations			**Provide Details**
H1N1 (Compulsory)			
Flu Shot			

Please check off any of the following addictive behaviours

Addictive/Behavior	Yes	No	How long?	Solutions
Gambling				
Eating				
Sex				
Internet/Texting				
Other				

Mental Health

	Yes	No	Explain or Comment
Psychological Disorders			
Depression			
Insomnia			
Other Pertinent Medication			
Client on Psychiatric Medication			
Client on Prescribed Drugs			
Other Information			

Physical Examination:

	Normal	Abnormal	Comments
Appearance			
E.N.T.			
Hair, Skin, Nail			
Muscular Skeletal			
Respiratory System			
Thyroid			
Cardio Vascular System			
Abdomen/Digestive System			

Is there any kind of medical / disease history that Whiskyjack Treatment Centre should be aware of?

Please note:

_____

_____

_____

_____

_____

Please comment on any abnormalities that the client may have that will prevent the client from participation in group sessions, one-to-one Counseling and living at the Whiskyjack Treatment Centre Residence for four months.

_____

Date of last X-Ray**:** _____

CLIENT IN TREATMENT PROGRAM SHOULD BE FREE FROM ALL MIND-ALTERING DRUGS. THE CLIENT IS NOT TO BE IN NEED OF ACUTE HOSPITAL CARE AND SHE/HE IS NOT TO HAVE ANY CONTAGIOUS DISEASES.

I have examined this client and find him/her to be able to attend the Whiskyjack Treatment Centre Program.

_____ _____

Name of Physicians/Nurse in charge (print) Signature of Physician/Nurse in charge

_____ _____

Name of Hospital/Nursing Station Date

Authorization for Non-Prescription Drugs

As per Child Care Facilities Licensing Regulations 53-Health and Safety and regulations 54 and 55-medications, we require that "all non –prescription drugs which are authorized by a qualified physician, licensed prescriber or dispensing pharmacist prior to their administration to individuals in residential care."

Approval may be in the form of a written standing order, by completion of this form, or through verbal consultation with the physician or pharmacist. Verbal authorizations must be documented and retained in the client's file.

The following non-prescription drugs may be administered to _____
(Name of Client)

as directed.

Cough Preparations _____
Common Cold Preparations _____
Antihistamines _____
Analgesic _____
Others _____
Indicate any known Allergies:
_____
_____

This authorization should be periodically reviewed and revised as required.

_____ _____

Doctors Name (Please Print) Date

Patient: _____

Treaty #: _____

D.O.B: _____

MHSC: _____

All documents must be signed and dated

Authorization for Release of Medical information

I, _____, the undersigned hereby authorize and direct you to furnish information to _____. Regarding medical attention received by _____.

_____
Date

_____
Signature

_____

Witness

Accreditation Consent
Client/Parent Consent

I, _____ agree and consent for my file to be reviewed and to be interviewed by the Accreditation Team for the Accreditation purposes at the Whiskyjack Treatment Centre Inc.

_____ _____

Signature of Client Date

I hereby give consent for child's file to be reviewed and for my child to be interviewed by the Accreditation Team for Accreditation purposes at the Whiskyjack Treatment Centre Inc.

_____ _____

Signature of Parent/Guardian Date

WAIVER FORM

Date: _____

I _____,
(Print name)

Give permission to Whiskyjack Treatment Centre Inc; to take *photographs, video images,* and *any likeness* of my family. I understand the purpose of the images will be used at the discretion of Whiskyjack Treatment Centre Inc; with the best interest of the client in mind. Any images of my family will not be used for any other purpose.

My signing the underlines I agree to the above statement and I understand the purpose of this WAIVER FORM.

Signed: _____Date: _____Initial: _____
(Adult name)

All documents must be signed and dated

PRE-ADMISSION CHECKLIST
Worker (Referring agent must review with client)

_____

WHAT TO BRING

_____

____ Provincial Health Card
____ Photo Identification i.e.: Drivers License, Status Card
____ Calling Card/Phone Card (available in Northern Stores)

Please feel free to contact the Intake if you have any questions or need clarifications on anything.

Note: Women are asked to bring long skirts for Traditional use.

Men are asked to bring shorts for sweat lodge use.
Please Note: The traditional teaching is part of the program. (Clients decision not to partake in the sweats.)

Personal Hygiene

____ Shampoo, Conditioner
____ Deodorant
____ Sanitary Products
____ Tooth Brush/Tooth Paste
____ Shaving Cream/Shavers
____ Soap/Lotion
____ Brush/Comb/Nail Clippers
Towels & Face Towels

Note: Items with any alcohol content (hairspray, Mouthwash) will be placed in a locked storage area

Clothing
Clothing should be suitable for seasonal weather.
Note: Laundry facilities available and laundry soap will be provided.
____Pants
____Shirt
____Underwear
____Socks
____Coat/Jacket
____Outdoor Clothing
____Shoes/Boots

____Indoor Slippers/Shoes
____Pajamas/Sleepwear
____Outdoor Clothing (Snow pants, gloves, toques, winter boots, etc.

Personal Items:
____Tobacco (for traditional use)
____Cigarettes Money (for personal use)
____Spiritual / Religious Items Musical Instruments
____Personal Craft Supplies

Things Not to Bring:

____Suggestive/revealing clothing
____Drug Paraphernalia
____Cameras or Video equipment
____Heating Pads, or electrical blankets
____Weapons, including pocket knives
____Valuable jewelry or expensive clothing

Please bring any school work if applicable to any school age children

Luggage/Personal Inventory Check

Luggage & Personal items will be checked and inspected in the Client's presence.

Cell phones and Devices are not allowed and will be locked in storage.

Covid-19 Questionnaire

Date: _____

1. Have you Travelled in the last 14 Days internationally including to the United States? Yes _____No _____
2. Have you had closer contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with cough and/or fever and who has traveled internationally within 14 days prior to their illness onset? (Contact may be in Canada or during travel) Yes _____No _____
3. Have you been in contact in the last 14 days with someone that is confirmed to be a case of COVID-19? Yes _____No_____
4. Have you travelled outside of the province or past the 53rd parallel (Prairie mountain region) in the last 14 days? Yes _____No_____
   Where? _____
5. Anyone in your household travelled outside the province or 53rd parallel? Yes _____No _____
   Where? _____

-Dry Cough: Yes _____No _____
-Fever: Yes _____No _____
-Sore throat/ hoarse voice: Yes _____No _____
-Headaches: Yes _____No_____
-Muscle aches: Yes _____No _____
-Shortness of breath or breathing difficulties: Yes _____No _____
-loss of taste or smell: Yes _____No _____
-Vomiting or diarrhea lasting more than 24 hours: Yes _____No _____
-Fatigue: Yes _____No _____

_____ _____

Client: WTC. Worker