Whiskyjack Treatment Centre Inc.
Youth Treatment Referral Package

Whiskyjack Treatment Centre Inc.

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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 Services
- Cultural and Traditional Teachings
- Education
- Family Program
- Group Educational and Personal Development Program
- Job Readiness
- Land Base Program
- Language
- Personal Life Management
- Recreation
- Recreation Planning
- Substance Abuse Program

TREATMENT PROGRAM INTAKE SCHEDULE

Intake Date	Discharge Date	Gender
September 4, 2024	December 13, 2024	Female
January 4, 2025	April 18, 2025	Male
April 21, 2025	August 8, 2025	Female

Client's Weekday Schedule

Time	Monday-Thursday	Friday	Time
7:00-7:45 am	AM alert-Shower/Clean Up	AM alert-Shower/Clean Up	7:00-7:45 am
7:45-8:30 am	Breakfast & Chores	Breakfast & Chores	7:45-8:30 am
8:30-9:00 am	Morning Walk	Morning Walk	8:30-9:00 am
9:00-10:15 am	Group Session Counseling Sessions	Group Session Counseling Sessions	9:00-10:15 am
10:15-10:30 am	Break	Break	10:15-10:30 am
10:30-11:50 am	Group Session Counseling Sessions	Group Session Counseling Sessions	10:30-11:50 am
11:50-12:00 pm	Wash up for lunch	Wash up for lunch	11:50-12:00 pm
12:00-1:00 pm	Lunch/chores	Lunch/chores	12:00-1:00 pm
1:00-2:15 pm	School/Counseling sessions	School/Counseling sessions	1:00-2:15 pm
2:15-2:30 pm	Break	Break	2:15-2:30 pm
2:30-3:30 pm	School/Counseling sessions	School/Counseling sessions	2:30-3:30 pm
3:30-4:50 pm	Journal writing/quiet time	Journal writing/quiet time	3:30-4:50 pm
4:50-5:00 pm	Wash up for Supper	Wash up for Supper	4:50-5:00 pm
5:00-6:00 pm	4:50-5:00 pm	4:50-5:00 pm	5:00-6:00 pm
6:00-7:00 pm	Gym/laundry/exercise	Gym/laundry/exercise	6:00-7:00 pm
7:00-8:00 pm	Counseling/Internet	Counseling/Internet	7:00-8:00 pm
8:00-9:00 pm	Sports/Internet/counseling	Sports/Internet/counseling	8:00-9:00 pm
9:00 pm	Wash up/Get ready for pm alert	Wash up/Get ready for pm alert	11:00 pm

CLIENT'S WEEKEND SCHEDULE

Time	Saturday	Sunday	Time
9:00-9:30 a.m.	AM alert, Shower, Clean-up	AM alert, Shower, Clean-up	9:00-9:30 a.m.
9:30-10:30 a.m.	Breakfast & chores	Breakfast & chores	9:30-10:30 a.m.
10:30-11:00AM	Morning Exercise	Morning Exercise	10:30-11:00AM
11:00-11:50AM	Life Skills Group Session	Life Skills Group Session	11:00-11:50AM
11:50-12:00P.M.	Wash up for Lunch	Wash up for Lunch	11:50-12:00P.M.
12:00-1:00 P.M.	Lunch & Chores	Lunch & Chores	12:00-1:00 P.M.
1:00-4:30 P.M.	▪ Laundry ▪ Traditional teaching ▪ Cultural activities ▪ Life skill activities ▪ Counseling Sessions	▪ Laundry ▪ Traditional teaching ▪ Cultural activities ▪ Life skill activities Counseling Sessions	1:00-4:30 P.M.
4:30-4:50 P.M.	Journal writing	Journal writing	4:30-4:50 P.M.
4:50-5:00 P.M.	Wash up for Supper	Wash up for Supper	4:50-5:00 P.M.
5:00-6:00 P.M.	Supper & Chores	Supper & Chores	5:00-6:00 P.M.
6:00-7:00 P.M.	Gym / Exercises Counseling Sessions	Gym / Exercises Counseling Sessions	6:00-7:00 P.M.
7:00-10:30 P.M.	Movies Night Sport Activities	Sauna Sport activities	7:00-10:30
10:30-11:00 P.M.	P.M. alert	P.M. alert	9:30-10:00 P.M.
11:00 P.M.	BEDTIME	BEDTIME	11:00 P.M.

WTC Youth Services Intake Form

This form is to be completed in full when applying to have a client admitted to Whiskyjack Treatment Centre.

Date of Referral: _____

Referral Worker: _____ Position: _____

Address: _____ Postal Code: _____

Phone #: _____ Fax #: _____

Referral Information:

Name: _____

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 _____

Child & Family Services Involvement:

Agency Name: _____

Phone #: _____ Worker's Name: _____

Client Status: Permanent Ward: _____ Temporary Ward: _____ VPA: _____

Family History:

Biological Parents: _____ Guardian: _____

Address: _____ Phone No: _____

Place of Employment: _____ Phone No: _____

(Please list all who are considered siblings by the client, including customary, step and foster siblings)

Name	Age	Health Status	Lives with

Extended Family:

Maternal: _____ Paternal: _____
Languages (spoken): _____ Other: _____

Education:

1. Does your client go to school? Yes _____ No _____
2. Does your client like school? Yes _____ No _____
3. Highest grade completed? _____
4. Name of School and last year attending this school: _____

Relationships:

5. Does your client live with: Mom _____ Dad _____ Alone _____ Friends _____ Extended Family Members _____ Siblings _____ Mom and Dad _____
6. How does your client get along with his/her family members? _____
7. Who does the client feel closest to? _____
8. Does he/she have any close friends? If so who? _____
9. Does he/she talk to any elders? Is he/she willing to listen? _____
10. Does he/she have a girlfriend or boyfriend? Yes _____ No _____
11. Is he/she sexually active? Yes _____ No _____

Medical History:

12. Does your client have any medical problems? (please identify) _____
13. Does he/she require a medical consent form? _____
14. Family Doctor's Name and telephone number: _____
15. Is your client currently on any medication? Yes _____ No _____
16. Does he/she have any allergies? Yes _____ No _____
17. Has the youth ever been diagnosed with FAS, FAE, or ADHD? Yes _____ No _____
18. Date of last visit to Dentist: _____
19. Date of last visit to Optometrist: _____
20. Date of last visit to Dr/Nurse: _____
21. Does he/she have any children? Yes _____ No _____
22. History of serious illness: _____
23. History of Physical Trauma (ex. Surgery, burns): _____
24. History of Physical Impairments (ex. Deafness, Walking, Blind) _____
25. Alcohol/Drug use by Mother during pregnancy: Yes _____ No _____

Legal Problems:

26. Has your client ever been in trouble with the law? Yes _____ No _____
27. Was alcohol or any other substances, such as "sniffing" or drugs involved during your client's legal problems? Yes _____ No _____
28. Is your client currently on Probation or on a court order? Yes _____ No _____

Name of Probation Officer: _____
Phone #: _____ Fax #: _____
Probation Order: From _____ To _____
Conditions: _____
Copy Attached: Yes _____ No _____

Does the client have a history of:

	Yes	No	Suspected	Provide Details
Fire Setting				
Cruelty to animals				
Destruction of property				
Criminal Involvement				
Physical aggression towards adults				
Truancy-Skipping school				
Running from home				
Sleeping disturbances				
Eating disorders				
Bed Wetting				
Adoption/Apprehension				
Self-destructive behaviours				
Portrayed any manner of abuse towards others				
Depression/Suicide Ideation				
Other noteworthy behaviours: Specify (Ex. Hearing voices, abandonment)				

Chemical Use History:

29. At what age did your client start sniffing _____
30. At what age did your client start alcohol _____
31. At what age did your client start using drugs _____
32. Has your client ever used any of the following?

Substance	Yes	No	How Long (Months/Years)
Gasoline			

Glue			
Cigarettes			
Air Fresheners			
Spray Paint			
Rubber Cement			
Nail Polish Remover			
Hard Liquor			
Marijuana			
Crystal Meth			
Fabric Protector			
Crack/Cocaine			
Beer			
Home Brew			
Prescription Drugs			
Non-Prescription Drugs			
Other:			

33. Has your client ever lost friends because of sniffing/huffing? Yes _____ No _____
34. Has your client ever gotten into physical fights when using? Yes _____ No _____
35. Has your client ever caused serious injury to others? Yes _____ No _____
    Please explain: _____
36. Does he/she have any medical, physical, psychological, emotional problems because of the use of solvents/substances? Yes _____ No _____
37. Does he/she feel that they have control over their use of solvents/substances?
    Yes _____ No _____ Explain: _____
38. Has he/she ever considered reducing or quitting? Yes _____ No _____
39. Has he/she been in previous any treatment for their use of solvents/substances?
    Yes _____ No _____ Where _____ When _____
40. How long did the client stay in the program? _____

Psychological Functioning:

41. Has your client ever spoken or wrote about killing him/herself? Yes _____ No _____
42. Has your client ever attempted to kill him/herself? Yes _____ No _____
43. How many times? _____
44. How did he/she attempt to kill him/herself? _____
45. Has the client frequently gone off on their own when he/she is depressed (unhappy)?
    Yes _____ No _____
46. Is the client sad/unhappy? Yes _____ No _____
47. Is there any known history of sexual abuse? Yes ____ No ____
48. Is there any known history of physical abuse? Yes _____ No _____

49. Is there any known history of emotional abuse? Yes _____ No _____
50. Please explain (ie: At what age? Has it been reported and what is the outcome or current status: _____
51. Is there any history of family violence that this child may have witnessed?
    Yes _____ No _____ Please Explain: _____
52. Has your client had any involvement with gangs?
    Please Explain: _____
53. Is there any known history of other forms of traumatic experiences? (Including complex grief, bullying)
    Yes ☐ No ☐
    Please Explain: _____

When a client is in a sober state:

54. Has he/she communicated with spirits that no one can see/hear? Yes _____ No _____
55. Has this happened? Never _____ Sometimes _____ Most of the time _____
56. Are these positive/negative experiences for the client?
    Please explain: _____
57. Are there times when people are unable to communicate with the client?
    Not at all _____ Sometimes _____ Most of the time _____ All of the time _____
    Please explain: _____
58. Has your client ever had any psychological testing or counselling? Yes _____ No _____

Outside Resources:

59. Are there any other agencies involved with your client and his/her family?
    Yes _____ No _____
60. If so, which ones and what services do they provide? (for example, community wellness)
    _____

Family:

61. Family Activities/Practices: (What do you see as a family?)
    _____
    _____
62. Family Roles/Relationships: (How they interact with each other?)
    _____
    _____
63. Status in the community: (How is the family perceived in the community?)
    _____
64. What type of belief system is practised? _____

65. How does he/she spend her leisure time? _____
66. Who are the other support people involved with the family? (example, Elders, Extended Family, Community Groups Community Workers, Community Wellness)

    _____

    _____

67. Is the client/family aware of the effects of solvents/substances?
    Client: Yes _____ No _____
    Family: Yes _____ No _____
    Community Worker: Yes _____ No _____
68. Does the family believe the client recognizes that he/she has a problem? What steps does the family want to take to address the problem?

    _____
69. Has anyone in his/her family or community received treatment for solvent/substance Abuse? Yes _____ No _____ Who _____
70. Are the parent(s) supportive of their child receiving treatment? (refer client consent form) _____
71. Upon the child's completion of the program, what type of support system do you see as effective/useful to help maintain healthy lifestyle of parent and child?

    _____

    _____
72. Are the extended family members supportive of the family seeking help and/or treatment for themselves or their child?

    _____

    _____
73. 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 _____
74. Identify any significant losses or areas that may be affecting the child related to unresolved Grief?

    _____

    _____

Referral Worker's Recommendations:

Indicate what areas of healing/issues he/she feels that we should concentrate on?

_____

_____

Any additional information that your client or family feels that might contribute to his/her treatment?

_____

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 Client: _____

Signature of Parent/ Guardian: _____

Signature of Referral Agent: _____

Signature of Agent: _____

Date: _____

AUTHORIZATION FOR RELEASE FOR INFORMATION

I, _____, Parent or Legal Guardian of the said

(Name of Parent)

Youth, _____, do hereby give my permission to release

(Name of client)

The following information:

_____ Birth Certificates

_____ Medical Records

_____ School Records

_____ Other Records, as required for Treatment

In respect of: _____

(Name of Client)

_____

(Date of Birth)

_____

(Band and treaty number, if Applicable)

Signature of Parent / Legal Guardian: _____

Signature of Referral Agent: _____

Date: _____

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			

Medical Information:

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

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 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: _____

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

PARENTAL PARTICIPATION FORM

The Whiskyjack Treatment Centre has mandatory Family

Treatment Component within the clients Treatment Program.

I, _____ and I_____

(Name of Parent/Guardian) (Name of Parent/Guardian)

Understand that it is important to be involved in the 4 week Family Treatment Program while our/my child,_____, is in treatment. We/I agree to participate upon request and to cooperate with the Whiskyjack Treatment Centre Team. Please provide the Criminal record check and Child Abuse register.

Signature of Parent / Guardian: _____

Signature of Parent / Guardian: _____

Signature of Referral Agent: _____

Signature of Witness: _____

Date: _____

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 _____, the parent / Legal Guardian of_____
(Print name) (Print Name)

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

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

Signed: _____ Date: _____ Initial: _____
(Parent/ Legal Guardian)

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