INTAKE PACKAGE – LAND BASED DETOX

Contact Information:
Mushkegowuk Okimawiwin Minopimatisiwinik Atoskawikamik
Askikan - Land Based Detox Program
11 Elm Street N. Timmins, ON. P4N 6A3
Phone: 705-268-3594
Health Fax: 705-268-0435

<u>Disclosure</u>

The information in this application is ***confidential*** unless you provide written consent for us to share it or unless you pose a risk to yourself or someone else.

The application helps us understand your needs to best determine how we can assist with your path to wellness. Please take the time to complete the application to the best of your ability; the more information you provide, the better. You can fill it in yourself, have someone you know, and trust help you, or call us at the number below to schedule a time to complete it together. There are some sensitive topics, so having a support person with you is recommended.

If you choose not to attend, please notify me at the below contact within ***48 hours*** to allow for the waitlisted participants to attend.

If you are on the waitlist, you will be notified within ***24 hours*** of the next upcoming session date.

If you have symptoms of COVID – 19, please call us to defer your admission. All participants are required to have a COVID test prior to admission, dependent to community covid protocols.

Intake Form

INTERNAL USE ONLY

Intake Date:
Land Based Session Date:
Intake done by:
Received:

REFERRAL

□ Self Name: ____ Phone#: ________________________________

□ Agency: __________________________________ Name: ____

Phone #: _______________________________________Email: ____

CLIENT INFORMATION

First Name:	Last Name:	
Date of Birth:	Alias Name:	
Spirit Name:	Preferred Name:	
Clan:		
Home Phone: Can we leave a message here? □ Yes □ No	Cell Phone: Can we leave a message here? □ Yes □ No	
Email:		Age:
Address:		PO Box #:
Town:	Province:	Postal Code:

Do you have a status card? ☐ **Yes** ☐ **No** ☐ **I don't know** ☐ **not applicable** ***Consent required for us to assist you if needed**	
First Nation:	**Status #:**
Do you have a Provincial Health Card? (OHIP) ☐ **Yes** ☐ **No** ☐ **I don't know** ***Consent required for us to assist you if needed**	
Health Card #:	
First Language Spoken:	**Language Understood:**
Is the applicant completing this form? ☐ **Yes** ☐ **No** **If no,** **Contact: ________________________________** **Phone: _________________________________** **Email: __________________________________**	**Does the applicant give us permission to contact the person completing or helping with this form?** ☐ **Yes** ☐ **No** (*If yes, please sign below)* **Signature: ____________________________** **Date: ________________**

EMERGENCY CONTACT INFORMATION

To be contacted in the event of an emergency (ex: hospitalization)

Name of Contact: **Relationship:** **Phone #:** **Email:**
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SUPPORT SERVICES

How many positive supports do you have in your life (including professionals)? ☐ **None** ☐ **1-3 people** ☐ **4-6 people** ☐ **7 or more**

Family/Supports:
(collected for after-care and care planning purposes)

Name: **Relationship:**
Name: **Relationship**
Name: **Relationship:**
Name: **Relationship:**

What support agencies are you involved with in your community?
(collected for after-care and care planning purposes)

Name: **Service Provider:** **Phone #:**	Consent for contacting them will be collected during after-care / care planning.
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Care Providers
(collected for intake and after-care / care planning purposes)

<u>Doctor/Nurse Practitioner and Clinic Name</u>: **Clinic Name / Address:** **Email:** **Phone #:**	Consent to Contact □ Yes □ No ***please fill out form in consent package**
<u>Counsellor:</u> **Clinic Name/Address:** **Email:** **Phone #:**	Consent to Contact □ Yes □ No ***please fill out form in consent package**
<u>Child Welfare Worker & Agency</u>: **Email:** **Phone #:** **Is treatment part of your service plan? □ Yes □ No**	Consent to Contact □ Yes □ No ***please fill out form in consent package**
<u>Probation/parole:</u> **Email:**	Consent to Contact □ Yes □ No ***please fill out form in consent package**

Phone #: **Court ordered attendance:** □ **Yes** □ **No**	
<u>Other Agency Name</u>: **Contact person's name:** **Phone #:** **Email:**	Consent to Contact □ Yes □ No ***please fill out form in consent package**
<u>Other Agency Name</u>: **Contact person's name:** **Phone #:** **Email:**	Consent to Contact □ Yes □ No ***please fill out form in consent package**

MEDICAL HISTORY

Refer to primary Care and harm reduction nurse

When was the last time you had a medical or regular visit with your doctor to discuss your health? □ **in the last 3 months** □ **4-12 months ago** □ **1-5 years ago** □ **over 5 years ago**
In the last 3 months, how many times did you visit a hospital emergency room? □ **none** □ **once** □ **2-3 times** □ **4-5 times** □ **more than 20 times**
Do you have any medical concerns that we should be aware of that may impact your ability to take part in the land-based detox Program? □ **No** □ **Yes, if yes please describe:**

Do you have any Allergies?	□ **Yes** □ **No**
Do you require an epi pen or allergy medication for reactions?	□ **Yes** □ **No**
Are you a Diabetic?	□ **Yes** □ **No**
Do you have High Blood Pressure?	□ **Yes** □ **No**
Have you tested positive for HEP C, HEP B, or HIV? **If yes, ____**	□ **Yes** □ **No**
COVID – 19 Assessment?	□ **Yes** □ **No**
COVID Testing Required? **Date of Test:** **Result:**	□ **Yes** □ **No**
NOTE: Referral to Primary Care or Harm Reduction Nurse to take Vitals	□ **Yes** □ **No**

Please List any prescription, non-prescription or herbal medications you are currently taking:

Name	Dosage (mg)	Time you take it	What is it for?

PSYCHOSOCIAL HEALTH

EDUCATION	
Level of Education	□ high School □ some college/diploma □ University □ training
Are you enrolled in school?	□ Yes □ No
Program Courses your taking:	

EMPLOYMENT HISTORY		
Are you currently employed?	□ Yes □ No	□ full time □ part-Time/causal
Current Employer:		

SOCIAL
Source of Income: □ Employment □ Employment Insurance □ Old Age Pension □ Canadian Pension Plan □ Social Assistance □ Workers Safety Insurance Plan (WSIB) □ Other____________________
Are you connected to the Exceptional Access Program? (EAP) □ Yes □ No

Have you thought about suicide in the last 3 months?	□ Yes □ No
Have you attempted suicide in the last 3 months?	□ Yes □ No

People who are seeking services often struggle with mental health and learning differences. To plan for your success, let us know your history of mental health and learning differences, and check the box that best describes the impact of issue.

	Do you experience	Formally Diagnosed	Age it started?	Major impact	Fairly serious	Some Impact
Anxiety	□ Yes □ No	□ Yes □ No				
Depression	□ Yes □ No	□ Yes □ No				
Bipolar Disorder	□ Yes □ No	□ Yes □ No				
Eating Disorder	□ Yes □ No	□ Yes □ No				
Obsessive Compulsive Disorder	□ Yes □ No	□ Yes □ No				
Post-Traumatic Stress Disorder	□ Yes □ No	□ Yes □ No				

Schizophrenia	□ Yes □ No	□ Yes □ No				
Social Phobia	□ Yes □ No	□ Yes □ No				
Attention Deficit Disorder	□ Yes □ No	□ Yes □ No				
Fetal Alcohol Effects / Spectrum	□ Yes □ No	□ Yes □ No				
Psychosis	□ Yes □ No	□ Yes □ No				
Oppositional Defiant Disorder (ODD)	□ Yes □ No	□ Yes □ No				
Learning Disability (not ADD/ADHD)	□ Yes □ No	□ Yes □ No				
Other that we should be aware of	□ Yes □ No	□ Yes □ No				

If you answered yes to any of the above questions, please tell us any coping strategies you use to help with these issues:

____

____

____

____

____

____

LEGAL	
Do you have a criminal record?	□ **Yes** □ **No**
Current Charges	
Court Date:	

FOUR SPHERES ASSESSMENT					
Thinking about your life in the last 3 months, circle the most appropriate response to the right:	**Very Poor**	**Poor**	**OK**	**Good**	**Excellent**
Physical Health	**VP**	**P**	**OK**	**G**	**E**
Emotional Wellness	**VP**	**P**	**OK**	**G**	**E**
Mental Wellness	**VP**	**P**	**OK**	**G**	**E**
Spiritual Wellness	**VP**	**P**	**OK**	**G**	**E**

SUBSTANCE INVOLVMENT

Please tell us about your use of drugs and alcohol over the last 3 months (90 days)		**How often**	**Last Used**	**Modality**
METHADONE, SUBOXONE or SUBLOCADE	□ **Yes** □**No**			

ALCOHOL	□ Yes □No			
TOBACCO (cigarettes/vape)	□ Yes □No			
MARIJUANA	□ Yes □No			
POWDER COCAINE	□ Yes □No			
or ROCK COCAINE	□ Yes □No			
INHALANTS (glue, gasoline, etc.)	□ Yes □No			
METH/AMPHETAMINES (ecstasy, MDMA, speed)	□ Yes □No			
TRANQUILIZERS not prescribed (benzos, ludes, valium, goofballs, roofies, Prozac)	□ Yes □No			
BARBITUATES (barbs, downers, sleepers, reds)	□ Yes □No			
FENTANYL	□ Yes □No			
KETAMINE ("k")	□ Yes □No			
OPIATES (heroin, morphine, oxy, perc's, hydro, codeine)	□ Yes □No			
HALLUCINOGENS (mushrooms, Datura, LSD, peyote)	□ Yes □No			
PCP (angel dust)	□ Yes □No			
OVER THE COUNTER MEDS (cough syrup, pain relievers, antihistamines)	□ Yes □No			
PRESCRIPTION DRUG(s) NOT prescribed (e.g., OxyContin, Ritalin) Which one: ____	□ Yes □No			
OTHER DRUGS:	□ Yes □No			
Which Substance(s) do you use the most?				
Which is your Substance choice (if you had access?)				
Do you Experience Psychosis? □ No □ Yes, If yes how often:				

Use acronym in modality section

(IV)-Injecting (PO)-By mouth - inhalants, vaping, smoking, (PR)-Per rectal (PV)- Per vaginal (SN) – Snorted

HOUSING

Do you currently have stable housing?	□ **Yes**	□ **No**
Do you consider this your home?	□ **Yes**	□ **No**
If not, where do you consider home?		
If not, what is your living arrangement? □ Living on the street □ Couch Surfing □ Shelter □ Other		
Do you have a safe place to go after Detox?	□ **Yes**	□ **No**
Are you houseless?	□ **Yes**	□ **No**
How many people in the home?		
What are your sleeping arrangements?		
How many hours of sleep do you get a night?		

FAMILY HISTORY/CULTURAL INFORMATION

Question	Response
Did any of your family members attend residential school?	□ **Yes** □ **No** □ **Not sure**
Were you, your parents, or grandparents involved with Child Welfare System?	□ **Yes** □ **No** □ **Not sure**
Are you aware of impacts of colonization?	□ **Yes** □ **No** □ **Not sure**
Do you feel connected to your cultural identity?	□ **Yes** □ **No** □ **Not sure**
Have you practiced any traditional teachings?	□ **Yes** □ **No** □ **Not sure**
Have you practiced any spiritual, religious teaching or practices (e.g., ceremonies, church, smudging, fasting etc.)	□ **Yes** □ **No** □ **Not sure**
Are there any specific spiritual practices that are important to you? **If yes, please describe:**	□ **Yes** □ **No** □ **Not sure**

Is there anything else you would like for us to know about you? **Please tell us here.**
What other Services/Supports do you require after The Land-Based Detox? **Please describe:**

Question	Response
Would you be interested in attending a mainstream treatment program?	□ **Yes** □ **No**
Would you be interested in a After Care/Relapse Prevention Program?	□ **Yes** □ **No**