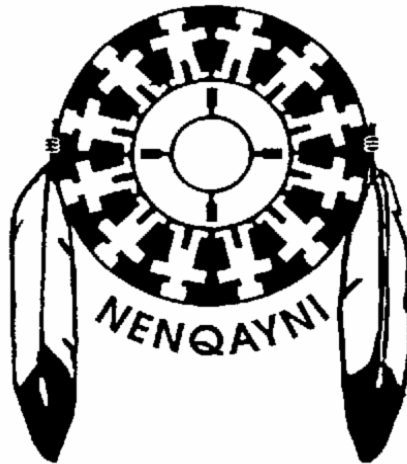


INTAKE / ASSESSMENT - REFERRAL FORM



NENQAYNI WELLNESS CENTRE SOCIETY

PO BOX 2529 WILLIAMS LAKE, BC V2G 4P2

PHONE (250) 989-0301

FAX (250) 989-0307

Email: Family Program Intake Coordinator Joan Evans: jevans@nenqayni.com

Email: Youth Program Intake Coordinator Sharon Duffy: sduffy@nenqayni.com

REFERALL AGENCY: _____

REFERRAL WORKER: _____

ADDRESS: _____

_____ POSTAL CODE: _____

PHONE: _____ FAX: _____

PROGRAM APPLYING FOR: (Please check one)

Family Drug & Alcohol Program (6 weeks) _____ Intake Coordinator: Ext. 206 (Joan Evans)

Youth & Family Inhalant Program (6 months) _____ Intake Coordinator: Ext. 204 (Sharon Duffy)



Today's date: _____

Referral worker name: _____

CLIENT PROFILE

1. IDENTIFICATION & PERSONAL INFORMATION

Last Name: _____ *circle* Male or Female

First Name: _____ Known as: _____

Birth date: _____

Medical #: _____ 10 Digit Status #: _____

Band Name: _____

S.I.N.#: _____

Language(s) used: _____

Home Address: _____
_____ Postal Code _____

Home Phone Number: (____) _____

Usual Occupation: <i>check</i> _____	Not Applicable _____	Permanent _____
_____	Self Employed _____	Retired _____
_____	Homemaker _____	Student _____
_____	Job Training _____	Temporary _____
_____	Seasonal _____	Unemployed _____
_____	Part-time _____	Social Assistance _____

Income Source: <i>check</i> _____	Income Assistance _____	Family _____
_____	Interest _____	Job _____
_____	None _____	Other _____

EMERGENCY CONTACTS

List someone that you do not live with who may be contacted in an emergency if no-one at your home phone number is available.

Name: _____

Phone : _____ Relationship to Applicant: _____

Name: _____

Phone : _____ Relationship to Applicant: _____



Have you been involved with any of the following:

Please check

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Ministry of Children & Families | <input type="checkbox"/> Therapists |
| <input type="checkbox"/> Court Worker | <input type="checkbox"/> Probation |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> R.C.M.P. |
| <input type="checkbox"/> Mental Health Worker | <input type="checkbox"/> Other _____ |

Were you raised by your natural parents? *Circle* YES NO
 If no, who raised you or has custody now? _____
 Who are you currently living with -(*please provide current address - page 2*)

Parents only:
 Have your children been apprehended? *Circle* YES NO
 If yes, when? _____ And for how long? _____

Will your children be coming to treatment with you? *Circle* YES NO

Will the children be under supervision of the ministry while in program here at Nenqayni Wellness Centre? *Circle* YES NO

Details of supervision order (attach any documentation): _____

Social Worker: _____
Phone: _____ Fax: _____

Legal Guardian(s): _____ Phone: _____

2. LEGAL HISTORY

Have you been involved with the legal system? *Circle* YES NO

If yes check the appropriate involvement below:

(Attach court documentation)

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Bail | <input type="checkbox"/> Probation |
| <input type="checkbox"/> Parole | <input type="checkbox"/> Under court order |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Alcohol related offence |

Name of probation officer: _____

Phone: _____ Fax: _____

List any upcoming court dates: _____

Previous charges or convictions please list: _____



3. SUBSTANCE ABUSE HISTORY

Describe any alcohol, drug, or inhalant issues in the clients family of origin:

Are you attending treatment for chemical use: *circle* YES NO

If yes give details below:

DRUG USED	AMOUNT USED PER DAY	AMOUNT USED PER MONTH	DATE LAST USED/COMMENTS
ALCOHOL (SPECIFY TYPE)			
MARIJUANA			
CRACK/COCAINE			
HEROIN			
INHALANTS (SPECIFY GAS, GLUE, OTHER..)			
PRESCRIPTION DRUGS (SPECIFY TYPE)			
INTERVENOUS DRUG (SPECIFY TYPE)			
OVER THE COUNTER DRUGS/NON PRESCRIPTION			
TOBACCO (CIGARETTES/CHEW)			
CAFFIENE			
OTHER			
OTHER			

Describe problems arising from your chemical use:

Check those that apply:

- Chemical abuse chronic
- Experimenting with A & D
- Social use only

- Children apprehended
- Sexual abuse victim
- Family domestic violence



Describe any previous attempt to deal with problem(s) arising from chemical/substance use:

- a) Self controlled abstinence
- b) Alcoholics Anonymous
- c) Narcotics Anonymous
- d) Other
- e) Did you have previous contact/counseling with above referring agency? *circle* YES NO

Describe: _____

- f) Have you attended treatment before *circle* YES NO
Name of previous Centre attended _____
- g) Did you complete the program *circle* YES NO
If no why not? _____
- h) Number of times in treatment in the past 2 years: _____
- i) Name of Treatment program you attended in last two years:

- g) Did you complete the program *circle* YES NO
If no why not? _____

4. EDUCATION HISTORY

For all school age children applying to either program fill out the school information page.

5. RELATIONSHIPS

- Living with: *check* Parents Single Parent
 Foster Parents Spouse
 Common Law
 Other Please Specify _____

Has there been any tragic deaths or other significant events in the applicant's life? (accidents/adoption, divorce, move, incarcerations, suicides, rape, murder etc.)

SPIRITUALITY

- What is your religious belief and preference?
 Traditional Native Roman Catholic
 Protestant None at the present time
 Other _____
 I have attended sweat lodge ceremony
 I have attended sun dance ceremony
 I have attended other spiritual ceremonies
 I would like to learn more



OUTSIDE RESOURCES

Please list any supportive persons (relatives and or counselors) and agencies in the community that you have contact with or could have contact with to help you be successful in treatment and as you continue to walk your healing journey after discharge. (Include phone numbers if known):

SOCIAL FUNCTIONING

Please check if the following issues have been a part of your life:

- Physical aggression or threatening behavior
- Verbal aggression/abuse
- Sexually aggressive behavior/promiscuous (verbal or physical)
- Difficulty following rules & regulations
- Withdrawal from substances (detoxification)
- Suicidal thoughts
- Suicide attempts
- Mental impairment
- FAS/FAE (Fetal Alcohol Syndrome/ Fetal Alcohol Effects)
- ADHD/ADD
- Depression
- Medical complications that may effect treatment
- Recklessness/ unhealthy risk taking
- Running away
- Co-dependant/Controlling
- Uncontrolled anger outbursts
- Criminal charges
- Other destructive behaviors (vandalism/arson - please specify below)
- self injury/ mutilation/ multiple piercing *-please give details*
- eating disorder - specify type _____

Comments:

RECOMMENDATIONS

Please add further insights that you feel may assist the intake worker/treatment team in assessing for possible acceptance. Attach any supporting letters or documents.



PRE-ADMISSION MEDICAL ASSESSMENT

LEGAL CLIENT NAME:

Known as (preferred name): _____

Medical Number: _____

Status Number: _____

Date of Birth: _____

Home Address: _____

Home Phone Number: (_____) _____

Referral Agency/Contact Worker Name: _____

Referral Agency/Contact Worker Address:

Referral Agency/Contact Worker Phone: _____

Fax: _____

CLIENT RELEASE:

I, _____ do hereby request and permit my physician, to release medical facts and assessment about myself, to Nenqayni Wellness Centre Society and the above named referral agency. The photocopy of my signature on this form is as valid as the original.

Signature: _____

Date: _____

TO THE PHYSICIAN:

The above-mentioned client is to be medically assessed as a requirement for participation in a residential treatment program at NENQAYNI WELLNESS CENTRE, Williams Lake, BC for Alcohol/Drug/Inhalant Abuse/Dependency. Nenqayni requires each client to have a complete physical examination prior to admission. Please include any relevant: lab results, operative reports or consultations, including psychological or educational psychology reports.



CARDIAC	_____	_____
MUSCULOSKELETAL	_____	_____
HAIR/ SKIN/ NAILS	_____	_____
BLOOD/ LYMPHATIC	_____	_____
EAR/ NOSE/ THROAT	_____	_____

9. **PHYSICAL EXAMINATION:** NORMAL ABNORMAL

APPEARANCE	_____	_____
EAR/ NOSE/ THROAT	_____	_____
HAIR/ SKIN/ NAILS	_____	_____
RETICULOENDOTHELIAL	_____	_____
MUSCULOSKELETAL	_____	_____
CARDIOVASCULAR	_____	_____
RESPIRATORY	_____	_____
CNS	_____	_____
ABDOMEN	_____	_____
THYROID	_____	_____
GENITO-URINARY	_____	_____

10. HEIGHT: _____

WEIGHT: _____ BP: _____

11. Please comment on any abnormalities in the functional inquiry or the physical examination. _____

12. Any problems prior to treatment that require follow-up?
 Please describe _____



13. Do you have any comments, suggestions or insights that might be helpful in terms of the client being physically (moderate physical exercise) and mentally able to participate in group and/or one-on-one counseling (i.e. Hearing problems) and living in residence for the duration of the program? _____

14. If any prescribed medications are required during treatment please list describe briefly instructions for the client: _____

FOR MINORS ONLY

15. Has a prenatal record and assessment record been completed for the mother of this child/youth?

Circle YES NO UNKNOWN

16. If yes, what risk factor (number) was assigned? _____

17. Briefly explain the nature of any identified risk factors (i.e. alcohol, drugs during pregnancy) _____

CLIENT NAME: _____

18. Was the Post-natal Follow-up done for this child? *circle* YES NO

If yes, briefly explain the findings and present health status of the youth. _____



I have examined this client and find him/her to be fit/not fit to attend treatment:

_____ FIT _____ NOT FIT

Physicians Signature

Date

Physicians Name PRINT

Office/clinic Address: _____

To the physician: Please refer the remainder of this medical assessment package to the appropriate nurse for completion.



CLIENT NAME: _____

DOB: _____

TB SCREEN

To the nurse: Please ensure that the following is filled out as completely as possible. Include copies of any relevant records. Children Four (4) and under do not require TB test

As indicated on the assessment and referral package page ii, TB testing is required before participating in a residential treatment program. Please ensure that TB testing has been completed and that the results are forwarded to the Wellness centre.

Has a Tuberculosis screening test been done for this client?

Circle YES NO

Date of test: _____

Results: NEGATIVE _____ POSITIVE _____

Chest X-Ray: circle YES NO

Interpretation: _____

Prophylaxis: _____ Date Started: _____

Has this client had any or all hepatitis B Immunizations? YES NO
If yes, how many? _____

Next due: _____

FOR DEPENDANT CHILDREN

Was the post-natal follow up done for this child? YES NO

If yes, briefly explain the findings, and present health status of the youth.

Is there an immunization schedule on file for this child? YES NO

If yes, what is presently required and will this be administered prior to entry into the treatment program?



DAYCARE LICENSING RELEASE

The following information is required for daycare age children only
(4) four and under.

Childs Name: _____ **Birthdate:** _____
dd/ mm / yr

Childs Name: _____ **Birthdate:** _____
dd/ mm / yr

Childs Name: _____ **Birthdate:** _____
dd/ mm / yr

Childs Name: _____ **Birthdate:** _____
dd/ mm / yr

I _____ do here by consent to my children attending
Parent/ Guardian (Print Name)

Nenqayni Wellness Centre, Daycare during our six-week program.

Parent/ Guardian (Signature)

- **Please include copies of immunization records for all daycare children.**



This page required for all school age children

SCHOOL INFORMATION

YOUTH NAME:		
<i>First</i>	<i>middle</i>	<i>last</i>
HOME ADDRESS:		
BIRTHDATE:		
PLACE OF BIRTH:		
TRIBAL HERITAGE:		
STATUS NUMBER:		
MEDICAL NUMBER:		
PARENT(S) or GUARDIAN(S) NAME(S): <i>circle one</i>		
NAME OF LAST SCHOOL ATTENDED:		
DATE LAST ATTENDED:		
SCHOOL PHONE:		
TEACHER NAME:		
PRINCIPAL NAME:		
<i>Circle</i>	ELEMENTARY	JUNIOR HIGH
	ALTERNATIVE SCHOOL	CORRESPONDANCE
		SENIOR HIGH
		OTHER
GRADE LEVEL:		
SCHOOL ON or OFF RESERVE?		
	<i>Circle</i>	ON OFF
COMMENTS:		



MAP - Where in the world is Nenqayni?

Nenqayni Wellness Centre
Williams Lake, BC
989-0301
1-888-668-4245
Residential Programs
Family Drug & Alcohol Program (6 weeks)
Youth & Family Inhalant Program (5 ½ months)

Quesnel to Nenqayni	103 km
Williams Lake to Nenqayni	21 km
Prince George to Nenqayni	205 km
100 Mile House to Williams Lake	91 km

