AADAC
Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

AADAC OFFICE USE ONLY **Client ASIST#**

Application for Residential Treatment

CONFIDENTIAL

This information is being collected under the authority of the Alcohol and Drug Abuse Act in order to provide AADAC services. If you have any questions regarding this collection please contact the Manager at one of the following centres.

To which program are you applying? (Be sure to check **one** box only)

☐ **NORTHERN ADDICTIONS CENTRE**
11333 – 106 STREET
GRANDE PRAIRIE AB T8V 6T7
PHONE: **(780) 538-6350** FAX: **(780) 538-6313**
E-MAIL: admissions.nac-treatment@aadac.gov.ab.ca

☐ **BUSINESS & INDUSTRY CLINIC**
11333 – 106 STREET
GRANDE PRAIRIE AB T8V 6T7
PHONE: **(780) 538-6316** FAX: **(780) 538-6313**
E-MAIL: admissions.biclinic@aadac.gov.ab.ca

☐ **HENWOOD TREATMENT CENTRE**
18750 – 18 STREET
RR6 LCD1
EDMONTON AB T5B 4K3
ADMISSIONS OFFICE: **(780) 422-4466**
SWITCHBOARD: **(780) 422-9069** FAX: **(780) 422-5408**
E-MAIL: admissions.henwood@aadac.gov.ab.ca

☐ **LANDER TREATMENT CENTRE**
BOX 1330
CLARESHOLM AB T0L 0T0
ADMISSIONS OFFICE **(403) 625-5600**
SWITCHBOARD: **(403) 625-1395** FAX: **(403) 625-1300**
E-MAIL: admissions.lander@aadac.gov.ab.ca

For further information on any of the above programs, see our web pages at www.aadac.com

SECTION ONE:

To be completed by the APPLICANT. Please PRINT clearly and answer all questions in detail.
Unanswered questions, incomplete or illegible answers may delay your admission.

1. What is your legal name? _____ (Last) _____ (First) _____ (Middle)

2. What name do you like to be called? _____

3. Is there another name that you use or have used? Example: your maiden name or an alias

   _____ (Last) _____ (First) _____ (Middle)

4. Mailing Address _____

   City _____ Province _____ Postal Code _____

5. Three months ago, were you a resident of a province or territory other than Alberta or Saskatchewan?

   ☐ No ☐ Yes

6. If yes, when did you take up residency in Alberta? _____ / _____ / _____
   (Proof of Residency may be required) day month year

7. Home Phone (___) _____ Alternate or Cell Phone (___) _____ Fax # (___) _____

8. ☐ Male ☐ Female Age _____ Date of Birth _____ / _____ / _____
   day month year

9. What is your marital status? (Check only ONE box that best applies to you)

☐ Single/Never Married ☐ Married/Common-law/Partnered ☐ Widowed ☐ Separated ☐ Divorced

10. What is your occupation? _____ Your employer? _____

11. If your application was prompted by any of the following, please check all the boxes that apply:

☐ AADAC office
☐ Child Welfare Worker
☐ AADAC Funded Agency
☐ Social Services/Income Security Worker
☐ Other(s) _____
☐ Physician
☐ Psychiatrist / Psychologist / Mental Health Worker
☐ Employer / Employee Assistance Program
☐ Court/Parole Officer / Probation Officer / Lawyer

12. Please describe in detail your alcohol, other drug use and/or gambling:

a) What do you use most often? _____

- Pattern of use (daily, binge) _____
- Amount of use per occasion _____
- How long have you used this substance? _____
- How long has this been a problem for you? _____
- Date you last used this substance? _____

b). Other drug used:

- Pattern of use (daily, binge) _____
- Amount of use per occasion _____
- How long have you used this substance? _____
- How long has this been a problem for you? _____
- Date you last used this substance? _____

c) Other drug used:

- Pattern of use (daily, binge) _____
- Amount of use per occasion _____
- How long have you used this substance? _____
- How long has this been a problem for you? _____
- Date you last used this substance? _____

d) Types of Gambling done: (e.g. VLT, Bingo, Horse racing)

- Pattern of gambling (daily, weekend, paydays) _____
- Amount of money gambled per occasion _____
- How long have you gambled? _____
- How long has this been a problem for you? _____
- Date you last gambled? _____

13. Describe in detail how your drinking, drug taking and/or gambling affected you and your life (for example, describe the effects on family relationships, employment, health, social life, etc.)?

14. Treatment history for alcohol, drug, or gambling problems:

    a) Have you previously attended AADAC residential treatment? ☐ No ☐ Yes

    b) If yes, check all you've attended: ☐ NAC ☐ Henwood ☐ Lander ☐ Business & Industry Clinic

    c) Other treatment agencies attended: _____

    d) Reason(s) for previous treatment: _____

    e) Approximate date(s): _____

    f) How long did you remain alcohol, drug or gambling free after treatment? _____

15. What are your reasons for wanting to attend Residential Treatment at this time? _____

16. Do you have any special needs or problems that we need to be aware of, such as reading and writing English, wheelchair accessibility, hearing difficulties, problems with stairs and long corridors? ☐ No ☐ Yes

    If yes, please give details: _____

17. Do you have any allergies (medications, foods, environmental)? ☐ No ☐ Yes *If yes, please list them:*

18. List all medications that you are taking, including all over-the-counter drugs such as Gravol, Tylenol, NyQuil, allergy medications, vitamins, herbal remedies etc.

19. Are you seeing a doctor regularly for any reason, including just refilling medication? ☐ No ☐ Yes

If yes, explain: _____

20. Please describe current medical problems, including chronic health issues, recent surgery, injuries, pain, etc:

_____

_____

21. a) Have you ever experienced mental health concerns: (for example, panic attacks, hallucinations/delusions, uncontrollable rage, mood swings, mental illness, etc.)? ☐ No ☐ Yes

If yes, what are the problems? _____

b) Please describe in detail how these problems affected you or others both in the past and currently:

_____

_____

_____

_____

_____

c) If currently under the care of a doctor/psychiatrist/psychologist, please give name & phone number:

Name: _____ Phone: _____

22. Have you had any thoughts of suicide or self-harm? ☐ No ☐ Yes

If yes, please describe in detail: _____

_____

_____

_____

23. If you have a history of criminal convictions, list the type and approximate dates of conviction(s):

_____

_____

_____

a) Describe any outstanding or pending legal charges: _____

_____

b) List upcoming court date(s) _____

c) Are you currently incarcerated / in jail? ☐ No ☐ Yes. If yes, which institution? _____

d) Are you on Probation, Temporary Absence or Parole? ☐ No ☐ Yes

If yes, for what offence: _____ Name of P.O. _____

P.O. Phone: _____ P.O.'s Agency/Office _____

24. Is there anything else you feel we should know?

_____

_____

25. Room and Board fees are **$15.00 per day for Alberta residents** and **$125.00 per day for out-of-province residents**. There is a fee of **$175.00 per day** for clients attending the **AADAC Business & Industry Clinic.**

PLEASE INDICATE METHOD OF PAYMENT:

☐ Cash ☐ Certified Cheque ☐ Money Order

☐ Visa ☐ MasterCard ☐ Social Services ☐ Health Canada/Indian Affairs

☐ Other PLEASE EXPLAIN _____

Social Services #: _____ Treaty Status #: _____ Band # _____

26. Please CAREFULLY READ the following before signing:

a) I understand in order to be admitted to residential treatment I must remain alcohol and drug free for at least five days prior to my admission date, and be well enough to participate in the program. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be referred to an appropriate detoxification setting before treatment.

b) I understand AADAC is not responsible for my transportation or any other personal costs I may incur (e.g., approved medications) while I am in treatment. I will bring and give to staff all medications I am taking.

c) I understand I cannot schedule any legal, dental, medical or personal business during the program.

d) I understand and agree to accept and attend all components of the treatment program as prescribed by AADAC, including all workshops, lectures, leisure and group counselling sessions.

_____ _____

Applicant's signature **Date**

27. I understand that, when processing this application for admission, AADAC may need to disclose my name to my physician or other individuals or agencies identified by me on this application. This disclosure would be required in order to obtain supplemental information that is necessary to determine my suitability for residential treatment, confirm my method of Room and Board payment and/or to confirm that I will be reporting for residential treatment as scheduled. I give my permission for AADAC to disclose my name for the reasons identified above.

_____ _____

Applicant's signature **Date**

SECTION TWO: To be completed by the Referring Person. Please print clearly.

If you are a self-referral, please check this box ☐ and skip this section.

Referring Person's Name: _____

Your Agency: _____

Professional or Personal relationship to Applicant: _____

Business Address: _____

_____ Postal Code: _____

Phone Number: _____ Fax Number: _____

Type of Referral. Check the box which most applies:

- ☐ AADAC
- ☐ Other Addictions Agency
- ☐ Relative/Friend
- ☐ Pastoral
- ☐ Other _____
- ☐ Health/Medical – Doctor
- ☐ Health/Medical – Other
- ☐ Mental Health
- ☐ Justice Legal
- ☐ WCB/Disability Management
- ☐ Business/Workplace, specifically:
  - ☐ EAP
  - ☐ Human Resources
  - ☐ Occupational Health
  - ☐ Private Employer

What is your assessment of the applicant's readiness and motivation for Residential Treatment?

_____

_____

_____

_____

_____

_____

Other than alcohol, drug or gambling, what issues does the applicant need to address while in the program?

_____

_____

_____

_____

Referring Person's Signature: _____

Date: _____

THANK YOU!

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APPLICANT'S NAME (PLEASE PRINT)_____

CONFIDENTIAL

SECTION THREE: Client Health Information

APPLICANTS MUST HAVE THIS FORM COMPLETED BY A PHYSICIAN. WHERE THE CLIENT HAS BEEN REFERRED FROM AN AADAC OPERATED DETOX, AN AADAC DETOX NURSE MAY COMPLETE THIS FORM

PLEASE NOTE: THE COST OF THE HEALTH QUESTIONNAIRE IS THE RESPONSIBILITY OF THE APPLICANT. This information is being collected under the authority of the Alberta Alcohol And Drug Abuse Act in order to provide AADAC services.

		Check one		
HISTORY OF:		**YES**	**NO**	**PLEASE EXPLAIN "YES" RESPONSES**
1	Allergies			
2	Central Nervous System			
3	Epilepsy, Withdrawal Seizures			
4	Pain: Acute, Chronic			
5	Mental Health Disorders			
6	Suicidal Thoughts			
7	Attempted Suicides			
8	Drug or Alcohol Abuse or Addiction			
9	Eating Disorder			
10	Sleeping Disorder			
11	Respiratory System Disorders			
12	Circulatory System Disorder B/P ____/ ____			
13	Gastrointestinal Disorder			
14	Hepatic Disorder (i.e. HCV +, HBV, Hepatitis)			
15	Pancreatic Disorder (ie. Diabetes, Pancreatitis)			
16	Urinary System Disorder			
17	Reproductive System Disorder			
18	Are you, or could you be pregnant? If yes, what is your due date? _____			
19	STDs, HIV+, AIDS			
20	Other health problems or recent hospitalization			
TB SCREENING: SYMPTOMS AND HISTORY				
21	Presence of cough lasting more than 2 weeks			
22	Weight Loss _____#lbs ____length of time			
23	Night sweats			
24	Fever			
25	Fatigue			
26	Haemoptysis (blood in Sputum)			
27	Recent or past exposure to TB			
28	Previous active TB and treatment			
29	Previous significant Mantoux results or Chest X-ray results			
30	Extensive Travel (or birth) in a country with a high incidence of TB			
31	Other risk factors for infection (aboriginal, elderly, homeless, health care worker)			
32	Poor general health status and risk factors for progression of disease			
ACTIONS				
33	Further TB screening or assessment required (if "yes" please fax results to Centre)			

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APPLICANT'S NAME (PLEASE PRINT) _____

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SECTION THREE: Client Health Information (continued)

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CURRENT MEDICATIONS (including prn meds and OTC)		
MEDICATION NAME	**PRESCRIBED BY**	**LENGTH OF TIME USED**

Are there any special problems (physical or psychological) that should be considered in the treatment of this applicant (for example, difficulty with stairs or long corridors, anxiety attacks, etc)

* **Please attach**:

- ⊙ Relevant medical, laboratory or radiological reports
- ⊙ Recent Psychological assessment or evaluations

Please remind the applicant: In order to be admitted to residential treatment, the applicant must be well enough to participate in the program. Typically, this requires at least five days of abstinence from alcohol and other drugs.

Are you the applicant's regular Physician? ☐ **Yes** ☐ **No**

Do you require a copy of the applicant's treatment discharge summary? ☐ **Yes** ☐ **No**

Physician (Print) _____ Signature _____

Mailing Address _____ Postal Code _____

Phone _____ Fax _____

AADAC Nursing Supervisor (Print) _____ Signature _____

Detox Site _____

I hereby authorize the above named physician to release to the nursing staff at AADAC, medical information which is required to assess my suitability for acceptance and admittance to the residential treatment program.

Applicant Signature: _____ **Date:** _____

Date Health Assessment Completed: _____