Ka-Na-Chi-Hih

Specialized Solvent Abuse Treatment Centre

Referral Package

**Please complete the package with the client to obtain valuable information that is being requested*

Ka- Na- Chi- Hih
Specialized Solvent Abuse Treatment Centre
1700 Dease St, Thunder Bay, On.
P7C 5H4
Phone: 807.623.5577 Fax. 807.623.5588

KA-NA-CHI-HIH

Specialized Solvent Abuse Treatment Centre

HISTORY

Ka-Na-Chi-Hih was initiated by Nishnawbe Aski Nation in 1996 and in January of 1997, admitted their first client. At that time, the program was situated at Smith Clinic and because of the need for more space, was relocated to the Lakehead Psychiatric Hospital (LPH) in March of the same year. The vision for Ka-Na-Chi-Hih at this time was to find a location that would be suitable and accessible to resources for the care and safety of its clients. It was not until August of 2004, that a place was strategically located in the city and purchased. Extensive renovations were required and completed in April of 2005. The vision of Ka-Na-Chi-Hih became a reality when our first client arrived at the new Centre on 1700 Dease St. in May of 2005.

MISSION STATEMENT

"In keeping with the sacred teachings of the creator, Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre will provide a nurturing and supportive environment for First Nation Youth who are embarking on their Healing Journey to Wellness of Body, Heart, Mind and Spirit."

VISION STATEMENT

"That all youth, who have been a part of Ka-Na-Chi-Hih will have gained the strength and skills necessary to continue on their path with pride, dignity, respect and a strong sense of identity. They will have achieved balance in their life long journey towards fulfillment and will be contributing members of their communities and to society."

PHILOSOPHY OF TREATMENT

- Ka-Na-Chi-Hih Treatment Centre believes in the continuum of holistic care which embraces traditional and contemporary teachings, skills and values which benefit those receiving and giving care.
- We believe in holistic health and that all individuals have the right to all the basic requirements of like which we hold sacred.
- We believe and respect the beliefs, values, culture, and spirituality of all individuals.
- We believe that each individual is worthy of respect, freedom and choice.
- We believe that each individual seeking self-awareness and personal growth has the right to enhance his/her abilities and skills, which enables them to function at their optimal level of health.
- We believe that each individual seeking healing at the Ka-Na-Chi-Hih Treatment Centre has the right to the programs and services, which ensure nurturing, support and empowerment to begin the journey to wellness of body, heart, mind, and spirit.

Please note that the information provided is confidential and will not be released without your prior knowledge and written consent.

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PROGRAM DESCRIPTION

Ka-Na-Chi-Hih is a 12 bed, long-term treatment program for chronic solvent abusers; in which a client may stay in our program for a minimum of 6 months and up to two years. Chronic solvent abusers are defined as those who have been abusing solvents daily, at least for a period of one year and which this use if affecting their life socially, physically, emotionally and spiritually. **The program serves First Nation Youth between the ages of 18 to 30, from across Canada**. Our programming is holistic in nature and we use traditional as well as contemporary models of treatment to help our clients deal with their habitual use of solvents.

Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre program has been distinguished currently consists of two treatment phases.

Phase I: The "Core Group Program" consists of 17 weeks of programming. These groups are designed to educate the clients so that they acquire healthier skills (life, living, coping, etc.) to deal with ongoing problems that occur in their lives. Along with the delivery of the core group program, each client has two-scheduled weekly one on one counseling sessions. Counselling sessions are also available to the client as needed. Once the client has successfully completes all 17 weeks of the required programming, and under the discretion of the clients primary counsellor, the client may enter into the second phase of treatment or the client may choose to return to his community for a home visit for up to 2 weeks. Additionally; as a National Treatment Centre, clients who reside out of province are required to return back to their community within 6 months to meet provincial standards of maintaining residency. If the Provincial standards are not met, the client will be identified as relocating becoming a new Ontario resident.

Phase II*:* The "Individualized Treatment Plan" is the second phase of the treatment program; in which consists of four areas the clients may choose to explore one or more focal points. Throughout this period, the clients are still able to exercise one on one counselling. The four components of individualized treatment are education, developing life skills, exercising self-help groups, and attaining job skills through volunteer programs. The purpose of the second phase of the treatment program is to meet the client's specific needs in personal self-development. Client goals include the utilization of the skills they have acquired, to execute confidence and take responsibility in positive decision making, to develop motivation and empowerment of self, to continue and maintain education for higher living, and to increase in awareness of community resources available.

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INTAKE

Initial contact will likely be through a verbal inquiry. At this point, information will be exchanged to determine whether there is a match between the client's needs and the Centre's program. If it seems that the potential client meets the eligibility criteria and that they could benefit from the program, then the Referral and Intake Information forms will be sent to the referring agent for completion.

The Referral and Intake Information forms will be completed and forwarded to the Centre. The potential client will be required to contact the Intake Worker to verify his voluntary to attend treatment for a minimum of 4 months and a willingness to participate in all treatment programming. Periodic clinical meetings assess the information on the waiting that has been retrieved from the referral form. If the potential client clearly meets the criteria, the referring agency will be advised of the status of the individual and an estimated period. If there is any question of the client meeting the criteria, the referring agency and individual will be advised of the areas in question, and further information will be sought.

Upon admission, the agent will provide related information regarding the client to give direction to staff to deliver the most suitable care. On arrival, the client will go through the intake process, which obtains personal information, and testing that will provide the level of cognitive impairment the client is currently suffering from and what outside services may be attainable.

AFTERCARE

Aftercare begins prior to discharge; the client is given support in accessing services for his transition back into the community. The client and primary counselor begin working on a relapse prevention plan specific to the individual, his family/friends and environment. Periodic follow-ups on done to see how well the client is doing. If there is any additional support that may be required referrals to the appropriate community resources or other support services will be recommended.

OUTREACH

Ka-Na-Chi -Hih provides Solvent Abuse Education to communities, schools, parents and support workers upon request. A booth consisting of Ka-Na-Chi-Hih and Solvent Abuse information is set up a local events and forums, on occasion. Ka-Na-Chi-Hih provides Crisis Intervention services to communities and families when an emergency arises.

Please feel free to visit our website at www.kanachihih.ca. Contact Intake/Outreach Worker *Olivia Pelky* – (807) 625-8351 or opelky@kanachihih.ca

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Referral Information:

This form is to be completed in full when applying to have a client admitted to one of the National Youth Inhalant Treatment Centers. Any blank areas many be considered incomplete.

Office Use Only:

Admission Date: _____ Discharge Date: _____

Referral Information:

Name: _____

Date of Birth (dd/mm/yyyy) _____Age Today: _____

Health Card Number:_____ Province of Registration:_____ Expiry Date:_____

Status Card Number (10 Digits):_____ Treaty Number:_____

Client Address and Phone Number: _____

_____

_____

Languages Spoken & Understood: _____

Referring Agent & Agency:

Agency: _____

Phone #: _____Fax #:_____

Address: _____

_____

Worker Name: _____

Worker's Title: _____

Worker's Email: _____

Emergency Contacts:

Name: _____ Relationship: _____

Phone #:_____ Community: _____

Name: _____ Relationship: _____

Phone #:_____ Community: _____

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Family:

Biological Parents: _____

Who the Client Lives With:_____

Guardian: _____

Address: _____

Phone #: _____

Place of Employment: _____

Work #: _____

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

Name	Age	Health Status	Lives With

Religious Beliefs: Traditional ☐ Roman Catholic ☐ Protestant ☐

Other: _____

1. What family activities/practices are done together? (Hunting, trapping, camping, etc...)

   _____

2. Does the family have addiction issues: who and if so to what?

   _____

   _____

3. How does the family interact with each other? _____

   _____

4. How is the family perceived in the community? _____

   _____

5. What other support is involved with the family? (Example, elders, extended family, community groups, community workers, CHR, NNADAP, CWPW) _____

6. Are the client and family aware of the effects of solvents & substances?

Client:	Yes ☐	No ☐
Family:	Yes ☐	No ☐
Community Worker:	Yes ☐	No ☐

7. Does the family believe that he has a problem? Are the parent(s) supportive of their child receiving treatment?

_____

_____

8. Has anyone in his family received treatment for solvent abuse or other addictions before? Please specify

_____

9. Is the family willing and able to come to our Treatment Centre to take part in the client's treatment?

_____

10. Has the client had any significant losses that may be related to unresolved grief?

_____

_____

Education:

11. Does your client go to school? Yes ☐ No ☐
12. Does your client like school? _____
13. Highest grade completed? _____
14. Name of school and last year attending this school _____
15. If answered No to client not in school, please explain why: _____

Relationships:

16. Does client live with: Mom ☐ Dad ☐ Alone ☐ Friends ☐
Extended Family Members ☐ Siblings ☐
17. How does your client get along with his family members? _____
18. Does he have any close friends? Is so who? _____
19. Does he talk to any elders? Is he willing to listen? _____
20. Is the client currently in a relationship? _____
21. Is he sexually active? _____ Does he have any children? _____

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Medical History:

- **THE MEDICAL FORMS ARE REQUIRED TO BE COMPLETED AND FAXED BACK TO THE INTAKE WORKER BEFORE ANY CONSIDERATION FOR ADMISSION INTO THE PROGRAM.**

Psychological Functioning:

22. Is the client capable of making their own decision? Yes ☐ No ☐
23. Does the client have issues surrounding anxiety? (excessive worry) Yes ☐ No ☐
24. Has the client ever felt hopeless and / or worthless? Yes ☐ No ☐
25. Has your client ever spoken or wrote about killing him self? Yes ☐ No ☐
26. Has your client ever attempted to kill himself? Yes ☐ No ☐
27. How many times? _____
28. How did he attempt to kill him self? _____
29. Has the client ever taken part in self-mutilating / self harm? How? _____

    _____
30. Does he have difficulty with anger?

    Explain: _____
31. Does the client require behavioural management? Explain: _____

    _____
32. Has the client ever demonstrated cruelty to animals? _____
33. Does the client have a history of aggression towards others? Explain: _____

    _____
34. Does the client have any special needs, learning disabilities or behaviour problems we need to be aware of?

    Explain:_____
35. Does the client like to get away and be alone when he is depressed (unhappy)? Yes ☐ No ☐
36. Does the client feel sad / unhappy?

    None of the time ☐ some of the time ☐ Most of the time ☐ All of the time ☐
37. Is there any known history of being a victim of child abuse? Yes ☐ No ☐
38. Please explain (At what age? Has it been reported and what was the outcome)

    _____

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39. Is there any history of family violence that the client may have been witness to? Yes ☐ No ☐

Please Explain: _____

_____

40. Has your client ever had any psychological testing or counselling? Yes ☐ No ☐

Please state when, for what purpose and by whom (where)?

_____
_____
_____
_____

- **PSYCHOLOGICAL / PSYCHIATRIC & MENTAL HEATLH DOCUMENTS ARE CRITICAL TO A CLIENTS HEALING. PLEASE LIST FACILITIES WHERE THE CLIENT MAY HAVE SOUGHT ATTENTION FOR ANY MENTAL HEALTH ISSUES.**

Chemical Use History:

41. At what age did the client start sniffing? _____

42. At what age did your client start alcohol? _____

43. At what age did your client start using other drugs? _____

44. Has your client ever used any of the following?

Substance used in the past, include all types even if use was only once.	YES	NO	Frequency (How often) [Daily, weekly, weekends, couple time a week, monthly]	Age of first use	Last date of use
Gasoline					
Glue					
Propane					
Nail Polish / Remover					
Spray Paint					
Rubber / Contact Cement					
Naphtha					
Hairspray					
Cleaners (fluids / sprays)					

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Substance abuse in the past, include all types even if use was only once.	YES	NO	Frequency (How often) [Daily, weekly, weekends, couple time a week, monthly]	Age of first use	Last date of use
Deodorizers					
Lacquer					
Beer					
Hard Liquor					
Home Brew					
Marijuana					
Cocaine					
Cigarettes					
Other					
Other					

45. Does anyone else in his/her family use solvents? Yes ☐ No ☐

46. If so, who? _____

47. Does he/she use solvents/substances with others or by him/her self _____

48. Has your client ever lost friends because of sniffing or huffing? Yes ☐ No ☐

49. Has your client ever gotten into any physical fights when using? Yes ☐ No ☐

50. Has your client ever caused serious injury to other? Yes ☐ No ☐

51. Does he have any medical or physical problems because of the use of solvents/substances?
Explain: _____

52. Does he have any psychological problems because of the use of solvents/substances?
Explain: _____

53. Does he feel that he has control over their use of solvents/substances? Yes ☐ No ☐

54. Has he ever been in any previous treatment for their use of solvents/substances? Yes ☐ No ☐

Where: _____When:_____

How long did the client stay in the program? _____

Where: _____When:_____

How long did the client stay in the program? _____

Where: _____When:_____

How long did the client stay in the program? _____

55. What are the reasons given by the client for using substance?

☐ To Make Friends	☐ To do like my friends do	☐ to be part of a group
☐ Because nobody likes me	☐ because nobody cares for me	☐ to have fun
☐ To forget my problems	☐ because nobody understands me	☐ because I'm bored
☐ Because life is too hard	☐ my family does it / it's what I learned	☐ I don't know

When the client is in a sober state:

56. Has he communicated with spirits that no one else can see or hear? Yes ☐No ☐

57. Are these positive or negative experiences for the client? Please explain & how often.

_____

58. Does the client have difficulty making close friends? Yes ☐No ☐

Outside Resources:

59. Are there any other agencies involved with your client and his family? Yes ☐ No ☐

60. If so, which ones and what services do they provide? (For example, NNADAP, CHR, CFS)

_____

61. Has the client ever accessed community services? (AA, NA, group counseling etc…)_____

_____

62. What has the client like to focus on in treatment?_____

_____

63. What resources / services are available in the community? _____

_____

64. Does the community have awareness on Solvent Abuse? Yes ☐No ☐

65. Would the community be interested in Solvent Abuse Education if it were available? Yes ☐No ☐

66. What other types of education would be community be interested in?

_____

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Legal: (Must be completed in full, if applicable)

67. Is your client involved in the legal system? _____

68. Please check the appropriate involvement below and send all related documents;

_____ Bail _____ Probation _____ Parole _____ Court Order

_____ Pending Charges _____ Currently Attending Court

69. Name of Probation Officer: _____

70. Phone #: _____ Fax #: _____

71. Probation Order: From: _____ To: _____

Conditions: _____

Please attach a copy of the probation order / conditions

72. Name of Lawyer: _____

73. Phone #: _____ Fax #: _____

74. Is the client required to attend Court, if so provide date and copy of order:_____

_____

75. What are the criminal offences: _____

76. Was alcohol, drugs or solvents involved with your client's legal problems? _____

- **ALL INFORMATION PERTAINING TO CURRENT LEGAL MATTERS AND PROBATION ORDERS ARE REQUESTED TO BE FORWARDED WITH THE REFERRAL PACKAGE. NO ADMISSION WILL BE CONSIDERED UNTIL ALL DOCUMENTS ARE OBTAINED.**
- **CRITICAL INFORMATION THAT IS WITHHELD, FALSE, MISLEADING, OR FABRICATED MAY RESULT IN THE CLIENTS DISCHARGE, ESPECIALLY IN THE EVENT WHERE THE SAFETY OF OTHERS IS AT RISK.**

Workers Recommendations:

Indicate what areas of healing he feels that we should concentrate on? _____

_____

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

_____

What is your assessment of the client's readiness and motivation to attend residential treatment? _____

_____

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Voluntary Program Participation Agreement

I do fully understand that Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre is a voluntary treatment program; therefore, I am willing to attend treatment and comply with all treatment related programming.

Treatment Programming includes two phases:

Phase I: The "Core Group Program" consists of 17 weeks of programming designed to educate the client so they build healthier skills. Each client will receive two weekly scheduled one on one counselling sessions, also available to the client as needed. Regular recreation and outings are additions to the daily program.

Once the client has successfully completed the first phase he may choose to continue with the second phase of treatment.

Phase II: The "Individualized Program" consists of four components; education, life skills, community supports, and job skills. The client may choose to explore one or more focal points. The purpose is to meet the client's specific needs in personal self-development.

In addition to the program structure stated above I agree to willingly accept all medical related treatment that will aid in my restoration of health.

I am aware that should I not choose to participate in programming or to follow the rules at Ka-Na-Chi-Hih, it could result in my discharge.

Print Name: _____
(Client)

Sign: _____
(Client)

Date: _____

Witness Name: _____

Witness Signature: _____

Date: _____

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Pre-Admission Agent Agreement

It is the policy of the Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre that;

- Any person admitted for treatment must be solvent free for at least **72** hours prior to admission.
- That the Referring Agent be responsible for making all travel arrangements and designate an appropriate escort for the safety of the client to and from Ka-Na-Chi-Hih. The Referring Agent MUST fax a copy of the travel itinerary or notify the intake department a minimum of 24 hours notice of the clients arrival.
- That the Referring Agent contacts the Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre once a month to review progress of the client.
- That the client may be returned to the Referring Agent if there is progressive non-compliance with the treatment program.
- That Referring Agent understands that Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre has a 30 day assessment period, if the Treatment Team is unable to provide the care required to meet the specific needs of the client.
- It is the responsibility of the Referring Agent to ensure that all information provided is true. Any false, misleading, fabricated or withheld information may lead to a client's dismissal from treatment due to inaccurate representation.

I understand the policies of the Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre and am in agreement to the responsibilities as the Referring Agent.

Agent Name: _____

Agent Signature: _____

Date: _____

Title: _____

Organization: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, of_____,
(Name of Client) (Address)

Born on _____,

Do hereby consent to the release, disclosure or transmittal of the following information:

____Treatment updates, obtaining and releasing information_____
____Medical, dental, legal, educational family history, identification_____
___Any other areas of information to assist with treatment planning_____

From: court workers, parole or probation officers, social workers, medical or psychiatry, practitioners, educators (school), NNADAP workers or other relevant professionals_____
(Agency Providing Information)

To __Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre_____
(Agency or Individual receiving Information)

For the purpose of: Information sharing for the purposes of treatment__
_____
_____

This consent is given from the date of signing and until 1 year from discharge or completion of the program. I am also consenting for Ka-Na-Chi-Hih to release such information only as necessary to other agencies, when required

Name (print): _____ Date: _____

Signature: _____

Witness (print name): _____ Date: _____

Witness Signature: _____

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Waiver: Release of Liability Form

This form must be completed by all individuals prior to participating in an event that involves a specific skill level and expertise by a trained person. The individual providing this activity has developed the expertise and experience to supervise and ensure safety of clients and staff participating.

There are times that clients may be requested to attend a special outing or event that goes beyond the scope of staff expertise and will require qualified persons to assist the clients to perform these activities. Clients and staff safety are the deciding factors of whether or not to participate in certain activities that go beyond the skill levels of staff.

I will be explained the activity that should I choose to participate in and have agreed to participate while releasing Ka-Na-Chi-Hih of any liability that may occur.

The activities or event that I will be participating in are as follows:

- Winter Activities – skating, ice fishing, hockey, sledding etc.
- Summer Activities – Swimming, boating, fishing, camping, hiking, biking, canoeing, sports etc.
- Cultural Programs – Sweats, smudging, medicine walks, drumming, feasts etc.
- Other Activities – Sports, games, recreational destinations etc.

I _____ Date of Birth _____ give my consent to attend these activities that are identified above or provided during the course of my treatment. I understand that no client attending treatment at Ka-Na-Chi-Hih will be coerced into participating or attending an event.

Signed: _____ **Date:**_____

Witness: _____ **Date:** _____

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CLIENT RULES

All clients will adhere to all rules, policies, and procedures at Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment, This includes the following:

1. Clients shall refrain from using all mind-altering substances while at the Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre.
2. Clients will refrain from possessing, using or distributing any form of contraband while at Ka-Na-Chi-Hih.
3. Disruptive, violent, aggressive behaviour will not be tolerated.
4. Clients are expected to actively participate in all aspects of treatment and treatment related activities.
5. Willful damage to Ka-Na-Chi-Hih property or others personal property will not be tolerated.
6. Clients will respect the privacy and boundaries of both clients and staff during their stay at Ka-Na-Chi-Hih.
7. Clients will behave in a responsible and respectful manner on and off Ka-Na-Chi-Hih property.
8. Clients are not permitted to sell, trade, barter and personal items.
9. Clients will be permitted personal phone calls only at their scheduled times and will be monitored. Family may call throughout the week.
10. Food and beverages will only be allowed in designated areas.
11. Clients are not allowed to access unrelated treatment areas without staff supervision.
12. Smoking will only be allowed in designated areas and at scheduled times. Clients under the age of 19 will not be granted the purchase of cigarettes.
13. A leave of absence without permission may be considered a voluntary discharge and will be dealt with accordingly.
14. Clients are **not** permitted to bring cell phones, iPod, iPad, tablets, laptops or any other form of communicative devices to treatment. MP3 players are allowed for music only.

A Client in breach of the rules can be immediately discharged at the discretion of the Treatment Team, Treatment Coordinator and/or Executive Director.

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Suggested Items to Bring

Clothing

- ✓ Pants / joggers / jeans
- ✓ Underwear / undergarments (season appropriate) / socks
- ✓ Sweatshirts / t-shirts / sweaters
- ✓ Gym clothes / swim suit
- ✓ Shoes / runners / slippers

Seasonal

- ✓ Parka / winter coat
- ✓ Mittens / gloves / toque / scarf
- ✓ Sandals / baseball cap
- ✓ Rubber boots / rain suit / winter boots

Toiletries / Personal Items

- ✓ Deodorant (non-aerosol) / toothbrush / toothpaste
- ✓ Combs / brush
- ✓ Pictures (without glass casing)
- ✓ **MP3 –music only (provided upon intake)**
- ✓ CD's suitable content only (improper or offensive CD's will be in lock-up)

DO NOT BRING ANY OF THE FOLLOWING…..
Lighters, hairspray, cologne/aftershave or lotion, shampoo, razors, lighter, mouthwash, hair spray, aerosols, gang paraphernalia, prejudicial articles, acne pads and any sharp objects or items that contain alcohol. Any of the stated will be immediately disposed of.

*All luggages will be searched upon program entry.

MP3's are for leisure time use only. Explicit music is unacceptable.
***Please leave laptops, iPod's, iPad's, cellular phones, tablets or any other communicative devices at home.**

Any letters or packages received during treatment will be searched; prohibited items will be immediately discarded.

I.D., moneys and tobacco products will be held by Ka-Na-Chi-Hih staff until appropriate time of use. These items will be returned to the client upon discharge.

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Completing the Referral Package

The Clinical Team may periodically review the waitlist for possible admissions. As the waitlist can become lengthy and the intake times may vary due to being a long-term facility it is important that the Referral Package is completed in full. Admissions are based on the information in completed Referral Packages.

1. Please ensure that each section in the Referral Package is completed.

2. Please ensure that the following documents are included and signed forms are forwarded with the Referral Package.

    a. Copy of Status Card, Health Card and any other ID
    b. School Transcript
    c. Voluntary Participation Agreement
    d. Agent Agreement
    e. Consent to Release of Information Forms
    f. Immunization Records
    g. Pre-Admission Medical Form (both sections)
    h. Medical Records
    i. Mental Health Records
    j. Probation / Court Orders
    k. Psychiatric Assessments
    l. Previous Treatment Discharge Summaries

And any other information that may be pertinent to the clients healing journey

After completion please fax the Referral Package direct to 1 (807) 623-5588 Attn: Olivia Pelky, emailed: opelky@kanachihih.ca, or it may be mailed Attn: Olivia Pelky, 1700 Dease St Thunder Bay, ON P7C 5H4

Please forward this information to the treatment centre at your earliest convenience at (807)623-5588

Ka- Na- Chi- Hih
Specialized Solvent Abuse Treatment Centre
1700 Dease St, Thunder Bay, On.
P7C 5H4
Phone: 807.623.5577 Fax. 807.623.5588

Client Medical Information

Please complete this section in a clear manner.

Name: -

_____
Last First Middle Name

D.O.B: _____ Status #: _____ Health #: _____
MM/DD/YY (10 digits)

Address:

_____
Street City Province Area Code

Next of Kin: _____
Name Relationship Phone #

History of:	Yes	History of:	Yes	History of:	Yes
Anemia		Fainting		Seizures	
Anxiety		Hallucinations / Delusions		Self Harm (cutting /burning)	
Asthma		Head Injury		Skin Conditions	
Back Injury / Problem(s)		Headaches (recurrent)		Strep Throat	
Blood Transfusion		Hearing Problems		Suicide ideation	
Brain Injury		Heart Murmur		Suicide attempts	
Chicken Pox		Hepatitis (A, B, or C please indicate)		Surgery (list)	
Depression		High Blood Pressure		➢	
Diabetes		HIV / AIDS		➢	
Disease/Injury of bones or joints		Injection Drug User		Tobacco Use	
Ear, Nose, Throat problems		Kidney Problems		Tuberculosis	
Eating Disorders		Learning Disability		Urinary Tract Infection	
Eye Problems		Liver Problems		Other:	

Allergies: Yes ___ No ___ **Lactose Intolerant:** Yes ___ No ___
If yes to what::_____

List any daily medication(s) and condition(s) for which the client is currently taking:

_____

_____

List any special needs of the client:

_____

Please list other services used for physical, mental health, or treatment purposes. (Provide approx.dates)

_____

Please note that the information provided is confidential and will not be released without your prior knowledge and written consent.

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Client Medical Information

*This section is **to be completed by the physician or Nurse Practitioner**, please print clearly.*

Name of Patient: _____

Last First Phone #:

Status #:_____ Date of Exam: _____

Health #: _____ DOB: _____

Physical Condition: Describe any health conditions that may interfere with physical activities.

_____

_____

Psychological Conditions: Provide general comments, medications and known attempts of suicide.

_____

_____

Are all immunizations up to date? (Required to be up to date in order to admission into treatment)

_____

Does the patient have a communicable infection / virus? (This is for the safety of all at the centre)

_____

Physical Exam:

HT: _____ WT: _____ BP: _____ Pulse: _____

	YES	NO		YES	NO
Cardiovascular			Mental Health Issues		
Cognition (average level)			Musculoskeletal System		
Ears, Nose, Throat (Systems Review)			Neuropsychiatry		
Eyes			Lymph		
FASE (Diagnosed or Suspected)			Respiratory		
Hygiene (Standard)			Skin		
Malnourishment			TB Skin Test Result		

Recommendations:

_____

_____

Name of Health Provider: _____ Date: _____

Community Served/Address: _____

Signature of Examiner_____

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Medication Administration Consent Form

Client Name: _____ D.O.B: (DD/MM/YYYY): _____

Date(s) Medication to be Given: _____

Reasons for Medication: _____

Name and Phone Number of Prescribing Doctor:

_____

Name and Number of Pharmacy:

_____

Directions for Storage: _____

Prescription: _____ Non-Prescription: _____

Medication Name	Dosage	Time(S)	Route	Possible Side effects

Parent/Guardian/Substitute Decision-Maker/Client Authorization: (Please initial beside each number)

1. I request that the above medication(s) be given during his admission in Ka Na Chi Hih as ordered by the physician/licensed prescriber. I also request the medication(s) to be given on outings as needed, as prescribed. _____
2. I release *Ka Na Chi Hih Specialized Solvent Abuse Treatment Centre* staff from liability in the event of adverse reactions resulting from taking the medication(s). _____

Please note that the information provided is confidential and will not be released without your prior knowledge and written consent.

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3. I give permission to *Ka Na Chi Hih Specialized Solvent Abuse Treatment Centre* to consult with the above-named client's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition being treated by the medication(s). _____
4. I give permission for the medication(s) to be given by designated *Ka Na Chi Hih Specialized Solvent Abuse Treatment Centre staff.* _____
5. I consent to have staff administer any medication that are/is prescribed to myself during my admission in *Ka Na Chi Hih Specialized Solvent Abuse Treatment Centre staff.* _____
6. Note: Medication is to be supplied in the original/prescription bottle. _____

Parent/Guardian/*Substitute Decision Maker/Client Name (Print):

_____

Parent/Guardian/*Substitute Decision Maker/Client Signature:

_____ Date: _____

Witness name (Print): _____

Witness Signature: _____ Date: _____

***Substitute decision-maker**: A person identified by the HCCA (Health Care Consent Act, 1996) who may make a treatment decision for someone who is incapable of making his/her own decision. The HCCA provides a hierarchy to determine who is eligible to be a substitute decisionmaker. The substitute decision-maker is usually a *spouse, **partner or relative. A power of attorney for personal care is not necessarily required to act as a substitute decision-maker. Under Personal Health Information Protection Act, 2004 (PHIPA), a substitute decision-maker is a person who is authorized to consent, on behalf of an individual, to disclose personal health information about the individual.*

Spouse means either of two persons who (a) are married to each other, or (b) live together in a conjugal relationship outside marriage and have cohabited for at least one year, are together the parents of a child, or have together entered into a cohabitation agreement under section 53 of the Family Law Act, unless they are living separate and apart as a result of a breakdown of their relationship.*

** **Partner** means either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives*

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Comments / Information: (Please add any/all additional information that will be helpful for treatment planning, staff information etc.)

Please forward this information to the treatment centre at your earliest convenience at (807)623-5588