PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED.
INCOMPLETE REFERRAL WILL NOT BE PROCESSED UNTIL FULLY COMPLETED.

HEALING JOURNEY REFERRAL

General Information	
Relative Last Name:	Relative First Name:
Anishnabie Name:	Relative Gender: F ☐ M ☐ Other:
Date of Birth: _____/_____/_____ Age: (dd) (mm) (year) Place of Birth:	Mother's Maiden Name:
Telephone Number: **May Benbowopka personnel contact you at the above telephone number:** Yes ☐ No ☐	Health Card Number: Expiry Date:
First Nation: Residing on First Nation: Yes ☐ No ☐ Duration?	Status Number:
Relative Full Address: **Please include Postal Code**	
Relative Emergency Contact: Relationship to Emergency Contact:	Telephone Number: Cellular Number:
Family Physician:	Telephone Number:

Family/Relationships
Who raised you? Parents ☐ Grandparents ☐ Extended Family ☐ Foster Parents ☐ Adoptive Family ☐
How many siblings do you have? Did your parents or any other family member attend a residential school? Yes ☐ No ☐ If yes, who?

Marital Status	**Living Arrangements**
Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widow/Widower ☐ Date/Year of Separation/Divorce/Widow/Widower:	With Parents ☐ With Children ☐ With Spouse ☐ With Spouse & Children ☐ With Relatives ☐ With Friends ☐ Alone ☐ Other:

Accommodation Following Treatment:

Do you have children? Yes ☐ No ☐ If yes, how many?

Are you a single parent? Yes ☐ No ☐ Do you reside with your children? Yes ☐ No ☐

Is a family service agency involved with your family? Yes ☐ No ☐

Name of Agency:

Do you have access to your children? Yes ☐ No ☐

What services is the agency providing for you and your family?

Personal Interest

Please list any hobbies, interests, strengths, skills and accomplishments you are proud of:

Education and Employment

Level of Education Completed:

Post-Secondary Course Completed:

Do you have difficulties with reading and writing? Yes ☐ No ☐ If yes, please identify:

Source of Income

Employment ☐ Employment Insurance ☐ Ontario Works ☐ Pension ☐ Savings ☐
No Income ☐
First Nation Financial Support Program ☐ Agency Name:
What other services are available to you through this agency?

Mental Health and Addictions

Have you ever been diagnosed with a mental health illness/disorder? Yes ☐ No ☐

If yes, please note the mental health illness/disorder: _____ _____
(Date or Year)

Have you ever been hospitalized for your mental health illness/disorder? Yes ☐ No ☐ _____
(Date or Year)

Have you ever experienced suicidal ideations or attempted suicide? Yes ☐ No ☐

If yes, please note when:

Addiction Services

Is this the first time you made an application to attend a treatment program? Yes ☐ No ☐

If no, describe what you feel was missing to meet your needs:

How can Benbowopka Treatment Centre meet your needs on your healing journey?

Please describe personal difficulties you are experiencing for which you now seek knowledge, understanding, and coping skills, all of which will assist you on your healing journey:

What is motivating you to make this journey?

Are you willing to attend Benbowopka Treatment Centre with a member of your own First Nation?
Yes ☐ No ☐

Identify any concerns or issues you may have while attending a treatment program at Benbowopka Treatment Centre:

Alcohol and Substance Use in the Past Year				
Please complete all sections				
Substance	**Age First Used**	**Frequency of Use**	**Amounts Used**	**Date of Last Use**

Legal Status

Criminal Court System:

Pending Charges: Yes ☐ No ☐ List Charge(s): _____

_____

_____

Probation: Yes ☐ No ☐ **Provide a copy of Probation Order**

Scheduled Court Appearance: Date: _____

Family Court System:

Are you involved with Ontario Family Court? Yes ☐ No ☐

Upcoming Ontario Family Court Date: _____

AFTERCARE PLANNING

To assist our First Nation Relatives on their journey, kindly please fully complete this form.

Referent: _____ **Agency:** _____

Telephone Number: _____ **Fax Number:** _____

Please indicate a date for relative's first session with you following his/her completion of the treatment program: _____

Identify any programs available on the First Nation or within your organization that would benefit our mutual relative on his/her journey:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

For the purpose of providing weekly updates on our mutual relative's progress, what date and time are you available for a member of our team to reach out to you? _____

Referent Signature: _____ **Date:** _____

MEDICAL ASSESSMENT

CLIENTS RESPONSIBILITIES: Please have all information completed by a Physician/Nurse Practitioner and return the completed form to Benbowopka Treatment Centre. Clients will not receive a treatment date confirmation without a completed Medical. PLEASE NOTE: Benbowopka Treatment Centre will not be responsible for any cost with having this Medical Release Information completed. Thank you.

Physician/Nurse Practitioner: (Please Print)	Telephone Number:
Client Surname:	First Name:
Date of Birth:	Gender: M ☐ F ☐
Telephone Number:	Marital Status:
Health Card Number:	
Client Address:	

Physical Health and Condition: (Note any limitations or restrictions)

Does the client have a disability or mobility condition? Yes ☐ No ☐
Does this patient have any type of respiratory illness or disease that may prevent the use of COVID-19 masks?
Yes ☐ No ☐
Please describe: _____

Please note any future medical treatments client may require. If yes, please note condition:

List all allergies: Is an Epipen required? Yes ☐ No ☐	Special diet required? Yes ☐ No ☐ Type:
Received Influenza Vaccine? Yes ☐ No ☐	Received Pneumococcal Vaccine? Yes ☐ No ☐

Psychological Condition: (History and Treatment)

PRESCRIBED MEDICATION
(Please use following form if necessary)

Medication and Dosage PLEASE HAVE MEDICATION BLISTER PACKED	Start and End Date of Medication	Psychoactive Effect (Yes/No)	Corresponding Diagnosis

Physician/Nurse Practitioner Signature:	Date:

Patient Consents to Sharing Personal Health Information with Benbowopka Treatment Centre.

Patient Signature: _____ Date: _____

Revised October 2020

PRESCRIBED MEDICATION

Medication and Dosage PLEASE HAVE MEDICATION BLISTER PACKED	Start and End Date of Medication	Psychoactive Effect (Yes/No)	Corresponding Diagnosis

CIRCLE OF CARE: CONSENT TO THE RELEASE OF INFORMATION AND PLANNING FOR AFTERCARE SERVICES FORM

I, _____, give permission for the mutual exchange of information between the Benbowopka Treatment Centre and:

☐ Psychiatrist:	☐ Physician:
☐ Hospital/Health Staff (Specify):	
☐ Probation:	☐ Lawyer:
☐ NNADAP/Referral Worker:	
☐ Medical Transportation Services:	
☐ Other Treatment Centers/Withdrawal Management Services:	
☐ Family/Significant Other (Specify):	
☐ Other (Specify):	

In respect of _____ _____
(Print Name) *(Date of Birth)*

as it relates to the provision of care/service while at the Benbowopka Treatment Centre and planning for discharge/aftercare services for the individual named herein. This consent shall remain in effect from this date until the purpose for which the information was disclosed has been achieved and/or I am no longer involved in this service. It is understood that I can revoke this agreement at any time either verbally or in writing. I have read, understand and agree to the terms and conditions outlined on the reverse side of this release.

_____ _____

(Signature) *(Witness/Staff Signature)*

Dated this _____ day of _____, 20_____.

Consent Withdrawn Date: _____, 20_____.

_____ _____

(Signature) *(Witness/Staff Signature)*

CIRCLE OF CARE: TERMS AND CONDITIONS FOR THE RELEASE OF INFORMATION AND PLANNING FOR AFTERCARE SERVICES

1. The Benbowopka Treatment Centre provides service through a team approach. From time to time this means client specific information must be shared with fellow employees of the Benbowopka Treatment Centre and with other significant supports involved in the care and/or treatment of the client.

2. Confidentiality shall be maintained by employees of the Benbowopka Treatment Centre except where there is imminent risk of harm to self or others or when subpoenaed by the court.

3. All other release/review of client information by employees of the Benbowopka Treatment Centre shall only be carried out with the expressed consent of the individual as outlined in the Circle of Care: Consent to Release of Information and Planning for Aftercare Services Form signed by the client.

CONSENT FOR DISCLOSURE OF ADDICTIONS MANAGEMENT INFORMATION SYSTEM DATABASE (AMIS)

AMIS is a National Native Alcohol and Drug Abuse Program (NNADAP) and Youth Substance Abuse Program (YSAP). Treatment Centers have used a national case management database since April 2014. The AMIS database collects evidence that can be used to inform client care, demonstrated the strengths of NNADAP/YSAP and support research initiatives over time. AMIS enables Treatment Centers to view and analyze client data quickly and complete reporting more efficiently. In addition, the information enables Treatment Centers to better understand and demonstrate a particular client's needs.

I, _____, _____
(PRINT CLIENT FULL NAME) (DATE OF BIRTH)

hereby authorize and consent to the release of the **AMIS Database/Record** pertaining to myself, which may be held by any NNADAP Treatment Centre in Ontario or any province within Canada **to be released to Benbowopka Treatment Centre for the purpose of continuing care.**

Relative Signature: _____ Date: _____

Witness Signature: _____

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