Blood Tribe Iitakamotsiipiohsopi Recovery Community Application

Voluntary bed-based services are generally provided in a communal living setting with a cafeteria style dining area, recreational activities and group counseling sessions.

Return **all pages** by fax, mail, or email to the appropriate centre below. The information you provide is private. This information is used to find a program that fits your needs best.

☐ **Blood Tribe Iitakamotsiipiohsopi Recovery Community** P.O. Box 229 Stand Off, AB T0L 1Y0 Phone: 403.737.8509 **Fax**: 587-422-2502 Email: btirc.intake@btdh.ca	**Referring Agency Information** Referring Agency: _____ Worker Name: _____ Contact Number: _____

Applicant Information

Legal Last Name	Legal First Name	Middle Name
Preferred Name	Date of Birth *(dd-Mon-yyyy)*	Administrative Gender ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____
Have you lived in the province for more than three months? ☐ No ☐ Yes	Alberta Health Care *(ULI, PHN)*	
First Nations Band Name (if applicable)	Treaty # (if applicable)	☐ Status (if applicable) ☐ Non-Status

Permanent Address and Contact Details

☐ No Fixed Address ☐ Encampment ☐ Shelter ☐ Couch Surfing

☐ Address	City	Prov	Postal Code
Primary Phone	Email	Preferred Method of Contact ☐ Phone ☐ Email	

Current Medications

Please list all medications you are currently taking (prescription, over-the-counter, and as needed).
Include dosage and how often you take them. If you are not taking medications, write "None."

Medication	Dose	How Often	Reason (Optional)

☐ I have attached my current Medication Administration Record (MAR), medication list, or pharmacy printout.
☐ I do not have a medication list available

Where do you currently receive your medications?

☐ Community Pharmacy: _____
☐ Other: _____

☐ OAT Clinic **Sober Date:**
☐ Hospital
☐ Detox/Stabilization

Medication information is required prior to admission. Providing a current medication list or MAR helps our medical team prepare your medications before you arrive and may help prevent delays in admission.

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To find out if live-in treatment is right for you, we need to collect some information from you. Please share as much information as you can on the following pages. You may be asked to submit additional information after discussions with an intake person.

A. Substances of Concern

Substance	Substance use?	How important is it to you to change/stop using?
Alcohol	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Heroin, fentanyl, other non-prescribed opioid	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Prescription opioid	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Benzodiazepines/sleeping medication	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Cocaine/Crack	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very

A. Substances of Concern Continued

Substance	Substance use?	How important is it to you to change/stop using?
Methamphetamine	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Prescribed stimulant	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Cannabis/marijuana	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Nicotine/tobacco	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Other _____	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very

B. Processes of Concern

Concern Type	Concern use?	How important is it to you to change/stop?
Gambling	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Sex addiction	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Pornography	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Video games	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Shopping	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very
Other _____	☐ Yes ☐ No	1 Not at all 2 3 Somewhat 4 5 Very

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C. Other Health Considerations *(Check 'yes' if any of the following concerns apply to you and may impact your treatment)*	
Category	**If yes, please tell us more**
Mental Health ☐ Yes ☐ No	
Seizures ☐ Yes ☐ No	
Vision ☐ Yes ☐ No	
Hearing ☐ Yes ☐ No	
Heart ☐ Yes ☐ No	
Stomach/digestion ☐ Yes ☐ No	
Kidneys ☐ Yes ☐ No	
Liver ☐ Yes ☐ No	
Joint pain ☐ Yes ☐ No	

C. Other Health Considerations Continued *(Check 'yes' if any of the following concerns apply to you and may impact your treatment)*	
Category	**If yes, please tell us more**
Movement/mobility ☐ Yes ☐ No	
Pregnancy ☐ Yes ☐ No	
Other ☐ Yes ☐ No	

D. Other Considerations *(Check all that apply)*		
Support Type	**Name**	**Contact Information**
☐ Family doctor		
☐ Spouse/partner		
☐ Child		
☐ Other family member *Relationship:* _____		
☐ Psychiatrist		
☐ Addictions counsellor		
☐ Other mental health professional *Relationship:* _____		
☐ Other		

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E. Have you attended any previous residential treatment programs:

☐ Completed (where) _____

☐ Not Completed (reason for discharge _____

F. Are you currently involved with any Opioid Treatment programs: (with who and when did you start treatment)

Suboxone _____

Methadone _____

G. Have you ever had thoughts of suicide or self harm: ☐Yes ☐ No

If yes, please describe: _____

_____

_____

H. Are you feeling suicidal or want to harm yourself in the present moment? ☐Yes ☐ No
If yes, please call or text 988 Suicide Crisis Helpline

I. Do you require any supports in treatment with:

☐ Reading _____

☐ Writing _____

J. Is there anyone you would like us to share information with about your application?

Name _____

Relationship _____

K. Family Information **To ensure the accuracy of our records, please list your family below (e.g. spouse/partner, dependants).**		**L. Please list any upcoming appointments, court dates, etc. that we need to know about when scheduling your treatment.**	
Name	**Relationship**	**Type of Appointment**	**Date** *(dd-Mon-yyyy)* **and Time** *(hh:mm)*

Carefully read the following

■ 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.

■ I understand Recovery Alberta 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.

■ I understand and agree to accept and attend all components of the treatment program as prescribed by AHS, including all workshops, lectures, leisure and group counseling sessions.

Signature	Date *(dd-Mon-yyyy)*

The collection of your health information on this form (including your Personal Health Number) is legally authorized by sections 20(b), 21(a) and 27 (b) of the Health Information Act (Alberta). Your information will only be used and disclosed as necessary to evaluate your eligibility for live-in treatment. If you have questions about this program call one of the treatment centres. If you have any questions about AHS' privacy policies and practices, contact Information and Privacy at 1-877-476-9874. You may also write to Information and Privacy at 10301 Southport Lane SW, Calgary, Alberta T2W 1S7 or email us at privacy@albertahealthservices.ca