Attention: NNADAP and Referral Agents

This letter is to introduce the Sagkeeng Mino Pimatiziwin Family Treatment Centre Inc. We are located in Sagkeeng (Fort Alexander), Manitoba, approximately 120 miles northeast of Winnipeg, Manitoba.

We offer a culturally-based program to deal with alcohol and other addictions that plague First Nation and Inuit communities. The program is seven weeks in duration and focuses on the family. Sagkeeng Mino Pimatiziwin Family Treatment Centre Inc. believes that people who are addicted to alcohol and drugs can overcome their addictions. It is with this belief that the primary purpose of Sagkeeng Mino Pimatiziwin Family Treatment Centre Inc. is to provide a holistic, spiritually-based Healing Centre where people are supported through processes that will start them on the road to recovery. This approach looks at the following realms within an individual as important to the healing journey.

Spiritual **Emotional** **Physical** **Mental**

Each person has the ability to confront problematic issues and secure their personal power to walk in health and wellness. Each of us is responsible for ourselves and our personal healing journey.

Any person on parole, probation and court order: referral worker must send a copy of that order to Sagkeeng Mino Pimatiziwin Family Treatment Centre.

While at the Sagkeeng Mino Pimatiziwin Family Treatment Centre Inc., clients must be free of all outside appointments, (court, probation, lawyers, doctors, dentists, etc.) In the case of an emergency the client's situation will be addressed in a timely manner. On-going treatment that may be required regarding a chronic health condition (i.e. Diabetes, Tuberculosis) can be accommodated by our local Sagkeeng Health Centre.

While the families are in treatment, they will participate in spiritual ceremonies, individual and family counselling sessions, parenting and life-skills lessons. In addition, we offer child care and education for children from certified professionals.

The staffs of Sagkeeng Mino Pimatiziwin Family Treatment Centre look forward to working with the families committed to leading a healthy lifestyle.

Any questions or concerns contact: Merle Fontaine-Intake/Aftercare Coordinator
Kim Spence, Treatment Manager

QUESTIONS FOR REFERRAL AGENTS

1. Have clients been attending regular Counselling sessions with you? □ Yes □ No
   If no, please explain _____
   _____

2. Have they been detoxed? □ Yes □ No
   We require that they be detoxed at least 1 week prior to coming in for treatment.

3. Is it mandatory that he/she come in for treatment? □ Yes □ No
   We have an open program, where the participant may leave if he/she feels that they are not ready for treatment. Healing is something that can only take place when the client is willing to change.

4. Is he/she of Aboriginal ancestry? □ Yes □ No
   Does he/she live one reserve? □ Yes □ No
   If non-status, please indicate the person(s)/agency that will be covering costs for the treatment program: _____

5. Is his/her travel arrangements made? □ Yes □ No

6. Is his/her **return** travel arrangements made? □ Yes □ No
   Comments: _____
   _____

7. If travel arrangements are not made, please explain why?
   _____
   _____

Please be sure to go through the **Referral Package** with them so that they fully understand the program and its requirements.

When attending the treatment program clients are required to bring:

- ✓ comfortable clothing/proper footwear for seasonal weather;
- ✓ personal hygiene items such as shampoo, face soap, shaving items, toothbrush/paste, etc;
- ✓ Any medication needed for the whole duration of the program;
- ✓ Phone calling cards;
- ✓ We do provide all towels/bedding needed.

Items not to include:

- ✓ Alcohol based items (i.e. mouthwash, after shave lotion, hairspray, etc)
- ✓ Non-prescription drugs that contain codeine, alcohol (i.e. Tylenol 1's, NyQuil, etc)
- ✓ Electronic items (i.e. clock, radios, mp3, stereos, etc)
- ✓ Explicit materials (i.e. lyrics/music or videos, clothing, etc)
- ✓ Gang affiliated clothing (i.e. bandanas, scarves, etc)

Clients should be made aware that a luggage check will take place upon arrival. All personal belongings are checked and inventoried.

INTAKE

Family Composition: (Incomplete forms will not be assessed for admission, and will be sent back to you for completion)

Adult: □ Male □ Female

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Treaty Number (10 digit): _____

Family Health Number (6 digits): _____Personal Health Number (9 digits): _____

P.O Box Number / Street Address:_____

Town/City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Messages: _____

Adult: □ Male □ Female

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Treaty Number (10 digit): _____

Family Health Number (6 digits): _____Personal Health Number (9 digits): _____

P.O Box Number / Street Address:_____

Town/City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Messages: _____

Child: □ Male □ Female

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Treaty Number (10 digit): _____

Family Health Number (6 digits): _____Personal Health Number (9 digits): _____

Address: _____ Telephone Number: _____

Caregiver (if not parent): _____ Telephone Number: _____

Child: □ Male □ Female

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Treaty Number (10 digit): _____

Family Health Number (6 digits): _____Personal Health Number (9 digits): _____

Address: _____ Telephone Number: _____

Caregiver (if not parent): _____ Telephone Number: _____

Child: ☐ Male ☐ Female

First Name: ______________ Middle Name: _______________ Last Name: _______________

Date of Birth: ____________________ Treaty Number (10 digit): ________________________

Family Health Number (6 digits): ___________Personal Health Number (9 digits): ___________

Address: __________________________________ Telephone Number: ___________________

Caregiver (if not parent): ______________________ Telephone Number: __________________

Child: ☐ Male ☐ Female

First Name: ______________ Middle Name: _______________ Last Name: _______________

Date of Birth: ____________________ Treaty Number (10 digit): ________________________

Family Health Number (6 digits): ___________Personal Health Number (9 digits): ___________

Address: __________________________________ Telephone Number: ___________________

Caregiver (if not parent): ______________________ Telephone Number: __________________

Child: ☐ Male ☐ Female

First Name: ______________ Middle Name: _______________ Last Name: _______________

Date of Birth: ____________________ Treaty Number (10 digit): ________________________

Family Health Number (6 digits): ___________Personal Health Number (9 digits): ___________

Address: __________________________________ Telephone Number: ___________________

Caregiver (if not parent): ______________________ Telephone Number: __________________

Referral Agent:

Agency: ____

First Nation: ____

Full Name of Worker: ___________________________________

Job Title: ____

P.O Box Number / Street Address:__________________________

Town/City: _____________________ Province: ____________ Postal Code: _______________

Telephone Number: _______________________ Messages: ____________________________

Fax: _________________________________ Email Address: ____________________________

MARITAL

1. How long has client been involved in present marital relationship?
   _____

2. Indicate the strengths holding the relationship together and the weaknesses that are causing problems.

   Marital Strengths? _____

   Marital Weaknesses? _____

3. Relationship Breakdown? i.e. Drugs, alcohol, violence, etc
   _____
   _____

4. What event(s) took place that caused the client to seek help at this time? Include details surrounding the event(s).
   _____
   _____

CLIENT'S PERSPECTIVE/PERCEPTION OF PROBLEM

1. Does client feel he/she has a chemical/co-dependency problem? □ Yes □ No

2. Does client express a need to change his/her life situation? □ Yes □ No

3. Are native culture and values significant for client's change? □ Yes □ No

4. Was client raised by natural parents? □ Yes □ No

5. Were there alcohol or drug problems in the family of origin while client was growing up (ie. Parents, guardian, sibling)? □ Yes □ No
   If yes, give
   details_____
   _____

6. Major areas affected by the dependency (such as leisure time, friends, relationships with children). Give details.
   _____
   _____

Maladaptive Behaviours: (Complete for each person over the age of 6 years old)

Behaviour:	*circle*	*one*	Client Name(s) & Involvement:
Aggressive to caregiver	Yes	No	
Aggressive to partner	Yes	No	
Difficult with authority	Yes	No	
Theft	Yes	No	
Cruelty to animals	Yes	No	
Fire Setting	Yes	No	
Bed Wetting	Yes	No	
Inappropriate sex acts	Yes	No	
Justice system contact	Yes	No	
School absences	Yes	No	
Violent outbursts	Yes	No	
Miscarriage	Yes	No	
Self mutilation	Yes	No	
Suicidal ideations	Yes	No	
Suicide attempt	Yes	No	
Vandalism	Yes	No	
Aggressive to children	Yes	No	
Interrupted Pregnancy	Yes	No	

Addictive Behaviours: (Complete for each person over the age of 13)

Behaviour:	Chronic:	Experimental:	Recreational:	Binge:	When begun:	Client Name:
Gambling:						
Illegal Drugs (list):						
Prescription Drugs:						
(list)						
Alcohol:						
Solvents:						
Cigarettes:						
Other (name):						

Justice System Contact:

Client Name:	Charge:	Date:	Outcome:	Lawyer:

Previous Treatment Attended:

Type of Intervention:	Precipitating Event:	Length of Abstention:	Name of Client(s):

Family Supports:

Name:	Relationship:	Telephone Number:

Family Strengths:

Willing to change		Community Supports		Access resources	
Humour		Close knit		Read information	
Show affection		Spiritual		Open to education	
Stable		Positive outlook		Resilient	
Rely on each other		Supportive friends		Involved in community	

Release of Information

We, _____ and _____ give permission for the release of:
(Name of Mother) (Name of Father)

□ Academic
□ Medical (includes recent Tuberculosis Screen Test)
□ Optical
□ Dental
□ Mental health
□ Child and Family Services
□ Other (specify)

Contact information about ourselves and our children, namely:

First:	Middle:	Last:	Month:	Day:	Year:

I understand that no other information will be released to any other persons without my written consent unless these persons have a court order or are concerned with medical treatment in an emergency situation. I also understand that I can withdraw or amend my consent to the release/request of information at any time.

All information is **Confidential**, in accordance with relevant statutes.

Consent for the release of information to the Sagkeeng Mino Pimatiziwin Family Treatment Centre will be effective for a six month period following the date of signature.

Signatures:

_____ _____
Mother Father

_____ _____
Witness Witness

_____ _____
Date Date

Participation Contract

We, _____ and _____;
(Name of Mother) (Name of Father)

Will actively participate and will ensure the active participation of our children in all treatment activities as developed with the staff of the Sagkeeng Mino Pimatiziwin Family Treatment Centre including:

□ Traditional ceremonies
□ Daily group sessions
□ Daily life skills lessons
□ Weekly family sessions
□ Weekly individual sessions
□ Academic lessons
□ Recreation activities
□ Daily chores
□ Cultural activities
□ Event outings

Clients must be responsible to provide their own tobacco, cloth and gift for use at ceremonies or celebrations.

Signatures:

_____ _____
Mother Father

_____ _____
Witness Witness

_____ _____
Date Date

Medical Assessment

The medical assessment has to be completed by Physician/Registered Nurse for each family member.

Client Personal Identification:

Date of Assessment: _____

First Name: _____Middle Initial: ____Last Name: _____

Known as (preferred name): _____

Birthday (MM/DD/YYYY): _____ Age: _____

Gender: □ Male □ Female

Family Health Number (6 digits):_____

Provincial Health Number (9digits): _____

Treaty Status Number (10 digits): _____

Informed Consent Must Be Completed With Client:

I, (client's name) _____ do hereby request and give permission to Physician/Registered Nurse, to release medical facts and assessment about myself to Sagkeeng Mino Pimatiziwin Family Treatment Center. The photocopy of my signature on this form is as valid as the original.

Client's signature:_____ Date:_____
(Legal guardian to sign if for child)

To the Physician/Registered Nurse

The above client is to be medically assessed as a potential participant in our seven week residential alcohol and drug treatment program. Our program is designed to help people who acknowledge their drinking or drug use has interfered with their effective functioning and who are physically and mentally ready to participate in a program of intense counselling to admission. The client should not require acute medical care at the time of admission to Sagkeeng Mino Pimatiziwin Family Treatment Center. Diseases are to be under control, especially communicable diseases.

Past Medical History

Please indicate whether the client has or had any history of the following:
Allergies: _____ Reaction: _____

Diabetes: _____ _____	Epilepsy, Seizures, Head Injury: _____ _____
Asthma/COPD: _____ _____	Skin Conditions: _____ _____
High Blood Pressure: _____ _____	Tuberculosis: _____ _____
High Cholesterol: _____ _____	Scabies, Lice, Impetigo: _____ _____
Heart disease/Stroke: _____ _____	Hepatitis/HIV: _____ _____
Pregnancy (LNMP): _____ _____	Sexually transmitted infections: _____ _____
Anxiety, Panic, Depression: _____ _____	Height: _____ Weight: _____
Suicidal Ideation, Previous attempts: _____ _____	Other Conditions: _____ _____

Are you aware of current or recent medical problems which may or may not require follow-up while client is in treatment? Yes: ____ No: ____
If yes, please explain:
_____
_____

Medication List

Name of Medication:	Indication:	Duration:

If the client is currently prescribed benzodiazepines, opiates or other addicting prescription drugs, please consider the need for such medications as clients may not meet the criteria for admission.

Is this client appropriate to taper off such medications? Yes: ____ No: ____

If yes, would you facilitate this taper while the client is attending treatment? Yes: ____ No: ___

Substance Misuse History

Please list if there is a history of substance misuse with any of the following:

Type:	Check all substances used:	Age of first use:	Frequency/How often used; daily, weekly, monthly:	Date of last use (M/D/Y):	Withdrawal seizure history (*)
Alcohol*					
Cannabis (pot, hash)					
Cocaine/Crack					
Crystal Meth					
Heroin					
Hallucinogen (acid, mushrooms, PCP)					
Barbiturates					
Benzodiazepines*					
Illicit Methadone					
Prescription Drugs					
Over the counter drugs (cough syrup, Gravol)					
Opiates (i.e. Tylenol #3, Percocet, Oxycontin)					
Inhalant					
Amphetamine					
Tobacco					

Has the client been hospitalized because of substance misuse? Yes ___ No ___

If answered yes, when was the client hospitalized and for how long?

_____

Tuberculosis Assessment –
Must be completed by a Physician or Registered Nurse.

As a prerequisite before participating in the residential treatment program, all clients over the age of 24 months must have TB Assessment and/or TB Screening done.

Signs & Symptoms

Have you experienced any of the following symptoms in the past three months?

Symptom	Yes	No	Date Started	How long did it last?
Pain with breathing				
Cough				
If cough, productive?				
Hemoptysis				
Weight loss				
Fever				
Night sweats				
Fatigue				
Lymphadenopathy				
Asymptomatic for tuberculosis				

Have you ever had TB? Yes ☐ No ☐

If yes, when (yyyy/mm): _____ Where? _____

Have you ever taken medication(s) for TB? Yes ☐ No ☐

Please list medication: _____

Do you recommend TB testing for patient? Yes ☐ **No** ☐

If no, please explain

_____

_____

_____

Tuberculosis Screen:

Please ensure that TB testing has been completed and that the results are forwarded to the treatment center.

Has Tuberculosis testing been recommended for this client?

Circle: Yes No

Date of test: _____

Results: Negative _____ Positive _____

Chest X-ray (if applicable) Yes: _____ No: _____ Results: _____

Prophylaxis (if applicable):_____ Date started: _____

For Minors Only

Has a prenatal record and assessment record been completed for the mother of this child/youth?
Yes: _____ No: _____
If yes, what risk factor (number) was assigned?
_____

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

Was the post natal follow up done for this child?

Yes: _____ No: _____

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

Name of Physician/RN: _____
Address: _____
City: _____
Province: _____ Postal Code: _____
Telephone: _____
Fax: _____

Office Stamp

_____ _____
(Medical Doctor or Nurse in Charge) (Date)