

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

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 **\$40.00 per day for Alberta residents** and **\$125.00 per day for out-of-province residents**. There is a fee of **\$200.00 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**

APPLICANT'S NAME (PLEASE PRINT) _____	CLIENT ASIST # _____
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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:

- | | | |
|--|--|--|
| <input type="checkbox"/> AADAC | <input type="checkbox"/> Health/Medical – Doctor | <input type="checkbox"/> Business/Workplace, specifically: |
| <input type="checkbox"/> Other Addictions Agency | <input type="checkbox"/> Health/Medical – Other | <input type="checkbox"/> EAP |
| <input type="checkbox"/> Relative/Friend | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> Pastoral | <input type="checkbox"/> Justice Legal | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> WCB/Disability Management | <input type="checkbox"/> 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!

Please Note: A completed medical form is required.