Gya' Wa' Tlaab Healing Centre Society

Referral Package[1]

[1] When faxing/scanning this package, there is no need to include this page

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

CLIENT ASSESSMENT/REFERRAL PACKAGE

REFERRAL WORKER INFORMATION

Name of Referral Worker:	Band/Agency:
Address:	Email:
Town/Province:	Postal Code:
Phone Number:	Fax Number:

CLIENT PERSONAL INFORMATION

Full Legal Name:		Also Known As:	
Sex: ☐ Female ☐ Male		Date of Birth *(dd/mm/yyyy)*	
Care Card #:		Out of Province: ☐ Yes ☐ No	
Status Indian, Metis, Recognized Inuit, or Other Indigenous Group? ☐ Yes ☐ No			
Status Number:		Band Name:	
Mailing Address	Street/Box Number:		
	City:	Province:	Postal Code:
Phone:		Email:	

CONTACT PERSON IN CASE OF EMERGENCY

Name:	Relationship:
Phone:	Alternate:

PROGRAM COST RECOVERY FEE: $50.00

Who will be paying the Cost Recovery Fee for this client?	
Fee will be: ☐ delivered by client on intake ☐ mailed after client arrives	

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

LEGAL ISSUES

- ☐ Bail
- ☐ Parole
- ☐ Probation
- ☐ Temporary Absence
- ☐ Currently involved in criminal court
- ☐ Currently involved in family court
- ☐ Charges Pending
- ☐ Not Applicable

Bail/Probation/Temporary Absence/Parole:

- a true signed copy of the order must be enclosed with the application
- all orders are dealt with on a case-by-case basis for intake purposes
- any pending/current/historic charges for sexual assault result in an automatic refusal to enter the program due to conditions of the Centre's land lease agreement.

FAMILY SITUATION

- ☐ Living Alone
- ☐ Living with Spouse/children
- ☐ Living with Parents
- ☐ Living with Other
- ☐ Single Parent
- ☐ Homeless
- ☐ Child/children in care of MCFD/ DAA

PRESENTING ISSUES: Why does the client want to be referred to treatment?

- ☐ Alcohol Abuse
- ☐ Prescription Drugs
- ☐ Solvents/Inhalants
- ☐ Methadone
- ☐ Requirement to keep job
- ☐ Reduced sentence/jail time
- ☐ Residential School Issues
- ☐ Sexual Abuse Survivor
- ☐ Other type of trauma
- ☐ Narcotics
- ☐ Hallucinogens
- ☐ Designer Drugs
- ☐ Court ordered treatment
- ☐ Family ultimatum
- ☐ Co-dependency
- ☐ Family Violence
- ☐ Relapse Prevention
- ☐ Process Addiction

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

SUPPORT SERVICES CURRENTLY BEING ACCESSED

- ☐ Addictions Counselling
- ☐ Family Counselling
- ☐ Men's Group
- ☐ Mental Health Counselling
- ☐ Religious Counselling
- ☐ Residential School Survivor Support Services
- ☐ Self Help Group
- ☐ Sexual Assault Services
- ☐ Survivors of Sexual Abuse
- ☐ Traditional Ceremonies
- ☐ Traditional Healer
- ☐ Treatment from a Psychiatrist
- ☐ Treatment from a Psychologist

EDUCATIONAL HISTORY

- ☐ No Formal Education
- ☐ Indian Residential School
- ☐ Elementary School
- ☐ Grade 8 – 10
- ☐ Grade 11 – 12
- ☐ Some College
- ☐ College Certificate
- ☐ College Diploma
- ☐ Some University
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ PhD

RESIDENTIAL SCHOOL

- ☐ Client Attended Indian Residential School
- ☐ Inter-generational Survivor (siblings, parents, grandparents, great grandparents attended Residential School)
- ☐ Not Applicable

LITERACY / SPECIAL REQUIREMENTS

- ☐ Illiterate (cannot read or write at a grade 8 level)
- ☐ Legally Blind
- ☐ Can read but struggles with Comprehension
- ☐ Not applicable

WORK HISTORY

- ☐ Contract Work
- ☐ Disability
- ☐ Employed Full-time
- ☐ Employed Part-time
- ☐ Primary Care-taker of young children
- ☐ Seasonal Work
- ☐ Student (full or part-time)
- ☐ Unemployed
- ☐ No history of working

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

SPECIAL REQUIREMENTS FOR ATTENDING PROGRAM:

Please Note: All boxes have to be checked off and there has to be two signatures plus the date at the bottom of the page.

STATEMENT OF COMMITMENT:

- ☐ I will fully participate in all aspects of the program, attend on time, and be respectful of all other clients and staff.
- ☐ I agree that I will only take medications that have been prescribed and/or approved by a Physician; whether they are prescription medications, over-the-counter medications, or vitamins/supplements.
- ☐ I agree that if I don't have my personal physician approve my OTC medications and vitamin/supplements on my Pre-Admission Medical Exam; that the Attending Physician of the Healing Centre will be responsible for approving/denying the use of these medications.
- ☐ I understand that the Gya' Wa' Tlaab Healing Centre has a **ZERO** tolerance policy in place for Violence. I agree that I will abide by this policy and find respectful ways of dealing with Rage and Anger issues. I will not engage in verbal abuse, harassment, and/or temper tantrums.

DECLARATION FOR ALL PATIENTS: CONTINUUM OF CARE

For the purpose of supporting the *"Continuum of Care"* and to ensure safe prescribing practices, I consent to allow the ATTENDING PHYSICIANS and the ATTENDING PHARMACIST of the GYA' WA' TLAAB HEALING CENTRE to:

- ☐ Contact my primary physician to discuss my medical status.
- ☐ Access my PharmaNet profile.
- ☐ Contact NIHB benefits, if applicable.

Furthermore, I assert that:

- ☐ I have been fully informed about this consent issue, and that I voluntarily give my consent to the sharing of my personal medical information in this manner.
- ☐ I understand that I can revoke my consent at any time.
- ☐ The photocopy of my signature on this form is as valid as the original.

Client Signature:	**Date:**
Referral Agent Signature:	**Date:**

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

REFERRAL AGENT SUMMARY

1. Would you describe your Client as being free of Crisis at the time of this referral?

   ☐ Yes ☐ No

2. Are you the primary Alcohol and Drug Counsellor for this client? ☐ Yes ☐ No
3. If yes, how much contact have you had in the last 6 months?

   ☐ Only emergency contact

   ☐ Initial A&D assessment

   ☐ 1–6 Counselling Sessions

   ☐ 7–20 Counselling Sessions

4. Has this client attended a Treatment Program in the past? ☐ Yes ☐ No

5. List all Programs that client has attended in the previous 2 years:

_____

_____

_____

_____

_____

_____

_____

Revised 24 November 2015

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

CLIENT PREADMISSIONS CHECKLIST: Pages 6 & 7

- **Please read this list carefully with your client. As you go through the list have the client check off each box with a check mark to show that he understands and agrees with each statement - then sign and date.**

THINGS TO NOTE ABOUT THE PROGRAM AND HEALING CENTRE

	The Sweat Lodge **is not** part of the local culture. There is no Sweat Lodge available to clients at the Healing Centre during the length of the program.
	It is important for the client to be open and honest about his MAS use especially for the days leading up to his intake date.
	The program is designed to become more intense and self-focused as the weeks go by. If the client is attending treatment to please someone /comply with something – other than his own free will – it gets harder to stay in the program. However, it can be done if he can stay focused on himself.
	The program is designed to be very interactive – every day there is information given that the clients must apply to their lives/ lifestyles - in real time. Clients are busy from early morning to late evening 6 days/week.
	Clients will start the program in a **1-week graduated isolation period**. This includes no phone calls, emails, or faxes. This moves into attendance at outside meetings and walks in the community. This is not negotiable.
	Clients will be eligible to receive one day pass/week starting on the 3rd Friday of the program.
	Clients are not permitted to walk unescorted in the Community of Kitamaat Village and will **only** be permitted to go on scheduled outings with the Staff of the Gya' Wa' Tlaab Healing Centre.
	Valuables: Safekeeping is available for money, airline tickets, and bus tickets.
	Items not allowed for use during the program shall be kept in Safekeeping until the Client is discharged.
	Laundry Facilities: Washing machines and dryers are available at no charge.
	Client Chores: Clients will be assigned chores for the duration of the program for their own rooms plus the areas that they use during their stay.
	The mailing address is: c/o Gya' Wa' Tlaab Healing Centre, PO Box 1018, Haisla, BC, V0T 2B0. **As a safety precaution, all mail must be opened in front of a staff member.**
	Telephone: use of the client phone for personal calls starts on the 2nd Wednesday of the program.

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

WHAT TO PACK:

	Sleepwear (slippers, t-shirt and shorts or pajamas).
	Fitness Wear (t-shirts, shorts or track pants and runners)
	Hobby/crafts/ musical instruments.
	Indoor **and** outdoor runners, shoes, boots.
	Comfortable weather suitable clothing sufficient for 7 days
	Toiletries: i.e. shampoo, toothpaste, shaving kit, personal hygiene products.
	Carvers may bring their tools. Tools will be used only at designated place and time during Intake.

WHAT NOT TO PACK

	Clothing suggestive of alcohol or drug use (including names of bars or taverns), or clothing that promotes sexism, racism or homophobia.
	Drug paraphernalia.
	Electronics such as laptops, amplifiers for musical instruments, portable DVD players, tablets, Mp3 players, video cams, etc.
	Weapons, including pocket knives.
	Mouthwash, body spray, cologne or perfume containing alcohol.
	Prescription Drugs that are not blister-packed.
	OTC drugs, Vitamins, Supplements that are opened.

I have read the Preadmissions Checklist and am aware of the conditions required of me while I am at the Healing Centre.	Signature of Client and Date

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

PRE-ADMISSION MEDICAL EVALUATION

PHYSICIAN NAME AND ADDRESS

Please stamp with the doctor's address stamp and include phone and fax numbers in the space below:

TO THE PHYSICIAN:

- **As the signing physician, you will remain the primary caregiver for this patient.**
- **The patient should not require any acute medical care at the time of admission.**
- **All communicable diseases should be in remission and properly medicated.**
- **The patient should be physically and mentally ABLE to participate in a residential program of intense counselling and activity.**

Please FAX all current prescriptions for this patient to our Intake Worker at 250-639-9815, one week prior to the Intake Day so that his medications can be blister-packed and waiting for him when he arrives.

- Patients cannot bring open medications into the Centre on Intake Day
- Patients can bring blister-packed medications into the Centre on Intake Day
- If the Patient arrives with open medications they will be put into safekeeping until they leave the Program as we cannot guarantee the purity of the medications

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

PRE-ADMISSION MEDICAL EVALUATION

Patient's Full Legal Name			
Date of Birth		Personal Health Number	
Status Number/ Citizenship No.		Name of Band/ First Nation	

INFORMED CONSENT: MUST BE COMPLETED WITH PATIENT

I, (Patient Name) _____ hereby request and give permission to Dr. _____, to release my Pre-admission Medical Evaluation to the *Gya' Wa' Tlaab Healing Centre*. I also consent to have the Healing Centre's attending physicians & pharmacist consult or inquire with the above-named physician on any of my medical needs while in treatment.

Patient Signature (below)	Date of Signing (below)

TB SCREENING: it is a requirement of First Nations Health Authority that a TB test be done and found to be acceptable prior to the patient entering a Residential Program.

Has a TB test be administered in the previous 12 months? ☐ Yes ☐ No	
If Patient can't do a skin test, please explain why:	
Date of Test:	Date Read:
Results of the Reading: please enclose report	☐ Negative, no further action required ☐ Postive, sent for an X-ray
Results of the X-ray: please enclose report	

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

OTHER COMMUNICABLE DISEASES: it is important to identify these types of diseases because treatment/prescription drugs may be limited in the north

Has the Patient tested positive for any of the following diseases:	Hepatitis A	☐ Yes	☐ No
	Hepatitis B	☐ Yes	☐ No
	Hepatitis C	☐ Yes	☐ No
	HIV/AIDS	☐ Yes	☐ No

PATIENT'S HEALTH AND FUNCTIONALITY: Please provide current details about the health and functionality of the patient.

Drugs Used During Last Episode: ☐ Alcohol ☐ Narcotics ☐ Poly Drug Use				
Date and Length of Last Using Episode:				
Height:	Weight:		Blood Pressure:	
History of Smoking	☐ Yes, current	☐ Yes, former	☐ Never smoked	
Blood/ Lymphatic	☐ Normal	☐ Abnormal	Comment:	
Cardiac	☐ Normal	☐ Abnormal	Comment:	
Cardiovascular	☐ Normal	☐ Abnormal	Comment:	
CNS	☐ Normal	☐ Abnormal	Comment:	
Ear/Nose/ Throat	☐ Normal	☐ Abnormal	Comment:	
Gastrointestinal	☐ Normal	☐ Abnormal	Comment:	
Hair/Skin/Nails	☐ Normal	☐ Abnormal	Comment:	
Musculoskeletal	☐ Normal	☐ Abnormal	Comment:	
Respiratory	☐ Normal	☐ Abnormal	Comment:	
Thyroid	☐ Normal	☐ Abnormal	Comment:	
Urinary	☐ Normal	☐ Abnormal	Comment:	

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

PATIENT'S HEALTH AND FUNCTIONALITY: continued

History of Seizures	☐ Yes	☐ No	Comment:
Diabetes	☐ Yes	☐ No	Comment:
Sexually Transmitted Disease(s)	☐ Yes	☐ No	Comment:
Dual Diagnosis or Co-morbidity	☐ Yes	☐ No	Comment:
Suspected Mental Health Issue	☐ Yes	☐ No	Comment:
History of Suicide Attempts	☐ Yes	☐ No	if yes, Date of Most Recent Attempt:
Psychiatric History	☐ Yes	☐ No	if yes, Diagnosis:

Do any of these conditions require monitoring during the stay at the Healing Centre? If yes, which one(s):

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

ALLERGIES: please indicate if patient has any kind of know allergy or intolerance to food or drugs.

ALLERGIES ☐ Yes ☐ No	Known Allergies:
INTOLERANCES ☐ Yes ☐ No	Known Intolerances:
Does the Patient require an EPIPEN or an ANA kit? ☐ Yes ☐ No If yes, the Patient must bring his own EPIPEN/ANA kit. Please prescribe one if needed.	

LIST OF MEDICATIONS: includes prescription, over-the-counter, and supplements

Medication	Condition	Prescribed Dosage	Taking Since

Client Name:_____ DOB:_____

Gya' Wa' Tlaab
Healing Centre Society

PO Box 1018, Haisla, BC V0T 2B0
Phone: (250) 639-9817 | Fax: (250) 639-9815
Email: gyawatlaab@haislanetwork.ca

METHADONE MAINTENANCE PATIENTS: This Screening is *Only* for Patients Who Are on Methadone

1. Prescribing Physician: Please Provide Contact Information

Physician Name:	City Located in:
Phone Number:	Fax Number:
Address of Clinic:	

2. History of Methadone use

Year in which it was first prescribed:	Initial Dose:
Date of most recent prescription:	Current Dose:
Carrying Privileges: ☐ Yes ☐ No	Any interest in stepping down: ☐ Yes ☐ No

3. MOST RECENT URINE RESULT FOR PREVIOUS 12 MONTHS:

PLEASE PUT A ✓ FOR POSITIVE RESULTS

Test Dates	Amphetamines	Benzodiazepines	Cannabis	Cocaine	Crystal Meth	Opiates

DECLARATION BY PHYSICIAN – To Be Completed for All Clients

☐ I conclude that my Patient **IS** physically and mentally fit and able to fully participate in all aspects of the treatment program at the Gya' Wa' Tlaab Healing Centre.

☐ I conclude that my Patient **IS NOT** physically and mentally fit and is unable to attend treatment at the Gya' Wa' Tlaab Healing Centre at this time.

Physician's Signature:	**Date:**

Client Name:_____ DOB:_____