SUNRISE

Native Addictions Services Society

1231 - 34th Avenue N.E., Calgary, AB T2E 6N4

(P) 403-261-7921 (F) 403-261-7945 Administration

(F) 403-269-5578 Client Admissions

(E) nasgeneral@nass.ca

<u>REVISED</u> - APPLICATION FOR ADMISSION

<u>Personal Information to be completed by applicant.</u>

Date:__________________

Surname:____________________________________ **Given Name:**____
Address:____
Phone Number:______________________ **Date of birth:**__________________ **Age:**______ **Sex: M**______ **F**_______
Band:____________________________ **Treaty #:**_________________________ **AHC#:**________________________
SIN#:_______________________ **Occupation:**_________________________ **Employer:**________________________
Marital Status:__________________________ **Number of Children and ages:**________________________________
Next of kin or person(s) to be notified in case of emergency:

Name:____ **Phone Number:**___________________________________
Address:____

Relationship to Applicant:____

Alcohol, drugs and gambling history:____
____
____

Provide any details regarding previous treatment experience for Alcohol/Drug/Gambling dependency:
____
____

Please indicate in what way(s) your drinking, drug use or gambling is a problem for you, and what your needs and expectations of our program are:
____
____

Have you ever been diagnosed with a Mental Health concern (i.e., depression, anxiety, bipolar disorder, personality disorder, etc.) □ Yes □ No. If Yes, What?____

If yes, are you currently on any medications to treat the disorder?

Please list name of medication(s):____

I understand and agree to accept the Treatment Program prescribed by SUNRISE – Native Addictions Services Society.
Applicant's Signature:____

<u>Please note: Sunrise Native Addictions Services reserves the right to refuse admission to clients it deems inappropriate for its programs.</u>

To be filled out by the Referral Source and / or Client:

Please describe the applicant's situation, and the present state of his/her dependency, including any information you have regarding particular problems:

PLEASE NOTE WE DO NOT ACCEPT CLIENTS ON PAROLE.

Family (relationships, etc.):

Employment (regular type of work, employment status, etc.):

Social (groups, activity, friends, etc.):

Legal /past and pending charges/ upcoming court dates/ parole/ probation/ mandated (please list):

Financial (source of income, debts etc):

Family Addictions History:

Financial and Other Requirements for Admission

All legal, medical, educational, employment and child-care services must be dealt with prior to admission . Clients will not be allowed to attend outside appointments/court dates while in the (6) week residential program (no exceptions).

Financial Requirements

- Please ensure arrangement has been made for funding for treatment.
- If paying room and board fees personally, Sunrise will only accept money orders or certified cheques**.**

Toiletries and Clothing

- Shampoo & Conditioner
- Hand and Body Soap
- Tooth brush, tooth paste
- Alarm clock
- Slippers, Moccasins
- Clothes according to season
- Deodorant
- Shaving material(shaving cream and razor)
- Hair brush and combs
- Hair Dryer/Flat Iron
- Swimming suit if available
- Workout clothes (runners, shorts, etc.)

Tobacco

- Enough for two weeks minimum.

Money

- Phone cards for long distance phone calls.
- Any extra money required or desired for leisure time activities, vending machines, or extra tobacco.
  ** Please note: Sunrise will not hold money for clients. **

Medications

- Please ensure all prescriptions have been filled and that there is enough for the (6) week duration.

ATTENTION

- Sunrise no longer supplies toiletries, please ensure you bring your own.
- Please do not bring in cell phones or any electronic devices such as i-pods. Such items will be put in storage.
- Be aware that large amounts of money will be your responsibility so bring only enough to get by.
- No outside food (i.e. Candy, pop, etc.) Sunrise has vending machines. All food and drinks will be disposed of upon admission.
- Don't bring any of your own bedding or towels, Sunrise will be supplying all bedding and towels. No stuffed toys.
- If you must use your vehicle for transportation to Sunrise, please be aware that you will not be able to use it during the (6) weeks of your treatment. Keys will be handed in to staff at time of admission.
- No couples, siblings, or immediate families are permitted to attend any Sunrise programs at the same time.
- New clients are expected to arrive Monday's between 9:00 am and 2:00 pm.

PLEASE KEEP THIS PAGE FOR YOUR REFERENCE

CLIENT CHECKLIST FOR RESIDENTIAL TREATMENT

TO BE READ AND SIGNED BY APPLICANT

(COUNSELLOR/REFERRAL WORKER PLEASE HAVE CLIENT COMPLETE AND SUBMIT WITH APPLICATION.)

APPOINTMENTS/MEDICATIONS

- □ I have a current Medical and Application Form Completed
- □ I am aware I will not be allowed to attend medical appointments or court dates, while I am in the (6) week program.
- □ I have rescheduled all medical and legal appointment until after I have completed my (6) week residential program. I have enough medication while I am in the (6) week residential program.
- □ I have my own personal toiletries. (see page 3)
- □ I have clean clothing; warm clothes for winter, clothes for recreation i.e. Runners, swimsuit, gym clothes.
- □ I will look after my clothing needs prior to admission to the centre.
- □ I am aware that there is a (72) hour minimum of sober/clean time expected prior to admission.
- □ I have made arrangements for funding for my treatment.
- □ I have made arrangements for any personal monies I may need during treatment.
- □ I will call the Admissions Clerk (2 times a week) to check in. I am aware that failure to do so will result in my treatment date being bumped or taken off the list completely.

OUT OF TOWN CLIENTS

- □ I am aware I am responsible for my return transportation if I am terminated from treatment or choose to leave the program early.
- □ First Nations Inuit Health Branch will provide a bus ticket home when I complete the program. (N/A if not a FNIHB client)
- □ **Please Note:** I am aware that I may be asked to leave the program if it is found that I have been dishonest or have disregarded any of the above points.

Please submit this checklist with application and keep a copy for your reference.

I, ____________________________________ understand and will abide by the above Checklist for Residential Treatment. I understand that providing incomplete and/or inaccurate information may be cause for refusal of admission or if already in Sunrise – termination from Sunrise Native Addictions Services Society Residential treatment.

Client Signature:____________________________________ Date:________________________

Referral Worker Signature:_____________________________Date:________________________

ATTENTION ALL REFERRING AGENCIES

Name of Referring Person and Agency:____

Phone Number:_________________ Address:_______________________________________

Please ensure the following has been completed prior to submitting the application.

1. **The application has been completed and reviewed._______(Initial.)**
2. **All information has been collected for the medical including the Tuberculosis Symptom Inquiry. ______(Initial.)**
3. **All legal charges past and present have been documented. The client maybe asked to leave the program if it is found they have been dishonest. _____(Initial.)**
4. **All arrangements for clothing, medical, dental, optical, legal, and financial concerns have been addressed prior to admission. If these concerns are not addressed (rebooked/cancelled) the client may be asked to leave the program. _____(Initial.)**
5. **Ensure the client has signed the agreement stating they are aware of the minimum of (72) hours sober/clean time before admission date. Sunrise reserves the right to drug test clients at any time._____(Initial.)**
6. **Ensure the client has a copy of the Financial and Other Requirements for Admission (Page 3). _____(Initial.)**
7. **Ensure funding arrangement have been organized. _____(Initial.)**
8. **Ensure transportation arrangements have been made including from the Greyhound Station to our Centre and to notify SUNRISE – Native Addictions Services Admissions Clerk. _____(Initial.)**

Please note: FNIHB will not fund clients on probation, community service, fine option, or conditional sentence.

Referral Worker Signature:____________________________ Date:____________________

CONFIDENTIAL PRE-ADMISSION MEDICAL ASSESSMENT

It is a requirement of Sunrise Native Addictions Services Society that any client seeking admission to this facility must present a recent medical examination. This form should be filled out by a Doctor and included with the client's application for admission.

Applicant's Name:____

Alberta Health Care Number:____

CLIENT'S CONSENT TO RELEASE INFORMATION:

I,____(client's name) hereby consent to the release of my medical assessment contained in this questionnaire to SUNRISE – Native Addictions Services Society.

____ ______________________________

Client or Applicant's Signature: Date:

Physician's
Name:____

Address:____

Phone Number:____

Are you the applicant's regular physician: Yes □ No □
Certain medical conditions and/or surgeries may restrict the client's participation in the treatment program. Please indicate whether this applicant has a history of any of the following:

Cancer		**Sexually Transmitted Disease**	
Epilepsy		**Heart Disease**	
Diabetes		**Tuberculosis**	
Allergies		**Respiratory Problems**	
Rheumatic Fever		**Hallucinations**	
Visual Problems		**Audio Problems**	
Alcohol/Drug Related Seizures		**Arthritis**	
Hepatitis/Liver Disease		**Kidney Disease**	
Other: please specify			

Please give details of any of the items checked above. (Use the other side of this page, if necessary)

____
____
____

Tuberculosis Symptom Inquiry – does this applicant present with any of the following symptoms:

□ cough ≥ 3 weeks (productive) □ fever
□ night sweats □ weight loss
□ fatigue □ hemoptysis

If symptoms suggest active TB disease, chest x-ray and sputum samples for AFB and culture are recommended and possible referral to Tuberculosis Services 403-944-7660

H1N1 Influenza Symptom Inquiry – Does this applicant present with any of the following symptoms:

□ symptoms of fever □ cough
□ runny nose □ sore throat
□ body aches □ fatigue
□lack of appetite □ diarrhoea
□ vomiting

If symptoms suggest active H1N1 please direct the client for proper treatment. Clients must be symptom free to attend Residential Treatment.

Psychological/psychiatric conditions might interfere with participation in the treatment program. Are you aware of any peculiarity or problems (i.e.: extreme anxiety, psychosis, depression, suicide attempts, etc.) that should be taken into account during treatment. Please detail:

____
____
____

Please List all Drug and Food Allergies:

____
____
____

Current Medications	**Prescribed by**	**Date Prescribed**	**Duration and Reason Prescribed**

I certify the above to be true to the best of my knowledge.

__________________________________ __________________________
Physicians Signature Date