Canadian Mental Health Association
North Bay and District
Mental Health – Addiction – Peer Support

Association canadienne pour la santé mentale
North Bay et District
Santé mentale – Toxicomanie – Soutien par les pair

Residential Addictions Treatment Program

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APPLICATION FORM (PAGE 1 OF 4)

Catalyst#: _____ **Referred:** dd_____ mm_____ yyyy_____

NBRH File: _____ **Referred:** dd_____ mm_____ yyyy_____

Client Information:

First Name: _____ **Middle Name:** _____

Last Name: _____ **Last Name at Birth:** _____

Alternate: _____ **D.O.B:** dd_____ mm_____ yyyy_____ **Age:** _____

Gender: ☐ Male ☐ Female **Health Card #:** _____

Street Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

County: _____ **Country:** _____

Home Phone: _____ OK to call: ☐ Y ☐ N OK to leave a message: ☐ Y ☐ N

Cell Phone: _____ OK to call: ☐ Y ☐ N OK to leave a message: ☐ Y ☐ N

Other Phone: _____ OK to call: ☐ Y ☐ N OK to leave a message: ☐ Y ☐ N

Current Location (if different from above) _____

Phone: _____ OK to call: ☐ Y ☐ N OK to leave a message: ☐ Y ☐ N

Emergency Contact: _____

Relation: _____ **Emergency Phone:** _____

Preferred Language: _____ **Ethnicity:** _____

Referral Information:

Referred: dd_____ mm_____ yyyy_____ **Referring Source:** _____

Referring Agency: _____ **Contact Person:** _____

Phone: _____

Are ADAT/GAINS Q3 tools completed? ☐ Y ☐ N ☐ In the Process
(If yes ask to receive Tracking Summary and Health Screening Form)

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Legal Issues:

Treatment Mandated/Required by: _____

Legal status: _____

Probation Start: dd_____ mm_____ yyyy_____ **Probation End:** dd_____ mm_____ yyyy_____

Charges Pending: _____

_____

Legal History: _____

_____

Relationship Status: _____ **Education:** _____

Children: ☐ Y ☐ N **Employment Status:** _____ **Employer:** _____

Income Source: ☐ ODSP ☐ Disability Insurance ☐ Ontario Works ☐ Employment
☐ None ☐ Retirement Income ☐ Employment Insurance

Date of Last Cheque Received: dd_____ mm_____ yyyy_____ **Amount:** $ _____

Substance Use:

Presenting Problem Substances (Drugs of Choice) 1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly 4. 3-6 times weekly 5. Daily 6. Binge 7. Unknown

1. _____ Frequency in last 30 days: _____
2. _____ Frequency in last 30 days: _____
3. _____ Frequency in last 30 days: _____
4. _____ Frequency in last 30 days: _____
5. _____ Frequency in last 30 days: _____

Substances used in the past 12 months: _____

_____

Gambling: ☐ Y ☐ N ☐ Unknown

Last Date Substance Used: dd_____ mm_____ yyyy_____ **Substance:** _____

Previous Treatment: ☐ Y ☐ N If yes, when and where: _____

Recovery Homes: ☐ Y ☐ N If yes, when and where: _____

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Health Status/Problems:

Visual Impairment: ☐ Y ☐ N ☐ Unknown **Hearing Impairment:** ☐ Y ☐ N ☐ Unknown

Mobility Impairment: ☐ Y ☐ N ☐ Unknown **Pregnant:** ☐ Y ☐ N ☐ Unknown ☐ N/A

Non medical injection use: ☐ Never ☐ Prior to 1 year ☐ Past 12 months ☐ Unknown

Number of overnight Hospitalizations in the last 12 months for physical problems: ___ ☐ Unknown

Reason for most recent Hospitalization: _____

Diagnosed with a Mental Health problem by a qualified Mental Health Professional?

Within the last 12 months: ☐ Y ☐ N ☐ Unknown Within lifetime: ☐ Y ☐ N ☐ Unknown

Most Recent Diagnosis #1: _____ Most Recent Diagnosis #2: _____

Hospitalized for a Mental Health problem?

Within the last 12 months: ☐ Y ☐ N ☐ Unknown Within lifetime: ☐ Y ☐ N ☐ Unknown

Received treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

Currently: ☐ Y ☐ N ☐ Unknown Within the last 12 months: ☐ Y ☐ N ☐ Unknown

Within lifetime: ☐ Y ☐ N ☐ Unknown

Name of service provider: _____ Phone: _____

Prescribed medication for a mental health problem?

Currently: ☐ Y ☐ N ☐ Unknown Within the last 12 months: ☐ Y ☐ N ☐ Unknown

Within lifetime: ☐ Y ☐ N ☐ Unknown

Name and dosage of medication: _____

Primary health care provider: _____ **Phone:** _____

Address: _____

Health Conditions/Problems/Allergies: _____

Methadone/Suboxone: ☐ Y ☐ N ☐ Unknown

Have you ever had a transmittable illness/disease: ☐ Y ☐ N ☐ Unknown

If yes, what: _____

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Current Medications:

Name: _____ **Dosage:** _____ **Frequency:** _____

Purpose: _____

Name: _____ **Dosage:** _____ **Frequency:** _____

Purpose: _____

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. • I understand that there are some circumstances in which this information may be re-disclosed to other parties and no longer protected by federal privacy laws. • I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission. • I have read all pages of this form and agree to the disclosures above from the types of sources listed.

Signed this _____ **Day of** _____ **, 20** _____

_____ _____

Printed name of applicant **Signature of applicant**

Additional Information: