Pelican High Peak
Youth Healing Lodge
70 Wellington Street
Sioux Lookout, ON P8T 1E1

Ka-Na-Chi-Hih Specialized
Solvent Abuse Treatment Centre
1700 Dease Street
Thunder Bay, ON P7C 5H4

Wakenagun
Youth Healing Lodge
5310 Highway 101 West
Timmins, ON P4R 0B5

CENTRALIZED REFERRAL FORM

PLEASE NOTE: ALL SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL.
Incomplete forms will be returned and may delay the intake process.

PLEASE CHECK OFF WHICH HEALING LODGE YOU ARE APPLYING FOR:

KA-NA-CHI-HIH (18-29 YEARS OLD)

WAKENAGUN (12-17 YEARS OLD)

PELICAN HIGH PEAK (12-17 YEARS OLD)

PART 1 – APPLICATION

A. PERSONAL INFORMATION

FIRST NAME: ______________________ LAST NAME: ______________________ MIDDLE NAME: ____________________

AGE: ________ DATE OF BIRTH (mm/dd/yyyy): ___________________ GENDER: _____________________ SEX: __________

ADDRESS: ____________________________________ PROVINCE/TERRITORY: ___________ POSTAL CODE: ____________

MARITAL STATUS: ____ PHONE #: ________________________________

EMAIL: ____

HEALTH CARD #: _______________________________ VERSION CODE: _________ EXPIRY DATE: __________________

BAND NAME: __________________________________ STATUS CARD #: ______________________

STATUS INDIAN INUIT MÉTIS NON-STATUS

LANGUAGE(S) SPOKEN: ______________________________ LANGUAGE(S) UNDERSTOOD:__________________________

REASON FOR REFERRAL:

B. PRIMARY CAREGIVER / EMERGENCY CONTACT INFORMATION

PRIMARY CAREGIVER

FIRST NAME: ____________________ LAST NAME: ______________________ MIDDLE NAME: ____________________

RELATIONSHIP TO YOU: ______________________ ADDRESS: ____

PROVINCE/TERRITORY: ______________ POSTAL CODE: _____________ HOME PHONE: __________________________

CELL PHONE: ___________________________ WORK PHONE: _________________________

FAX: ________________________________ EMAIL: ____

EMERGENCY CONTACT *(IF DIFFERENT FROM PERSONS ABOVE)*

FIRST NAME: ____________________ LAST NAME: ______________________ MIDDLE NAME: ____________________

RELATIONSHIP TO YOU: ______________________ ADDRESS: ____

PROVINCE/TERRITORY: ______________ POSTAL CODE: _____________ HOME PHONE: __________________________

CELL PHONE: ___________________________ WORK PHONE: _________________________

FAX: ________________________________ EMAIL: ____

C. REFERRAL INFORMATION

REFERRAL SOURCE: ____

FULL NAME: ___________________________________ RELATIONSHIP TO YOU: _________________________________

WORK PHONE: ____________________________ CELL PHONE: ___________________________________

FAX: _______________________________ EMAIL: ____

IF WE CANNOT REACH YOU, IS THERE SOMEWHERE WE HAVE CONSENT TO LEAVE A MESSAGE FOR YOU?

____

D. LEGAL INFORMATION

DO YOU HAVE ANY CURRENT ISSUES WITH THE LAW? YES NO

IF YES, PLEASE LIST ALL LEGAL CHARGE(S) / OFFENCE(S), INCLUDING ANY THAT ARE PENDING: __________________

____

____

PLEASE CHECK OFF ALL THAT APPLY:

CRIMINAL COURT FAMILY COURT DRUG COURT TREATMENT PROBATION

CHARGES PENDING COURT REFERRAL COURT ORDER RESTORATIVE JUSTICE

NO INVOLVEMENT

DO YOU CURRENTLY HAVE A PROBATION OFFICER? YES NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF PROBATION OFFICER: ____

PHONE #: __________________________________ FAX #: ____________________________________

EMAIL: ____________________________________

PROBATION ORDER – FROM: ______________________________ TO: ________________________________

CONDITIONS: ____

____

____

DO YOU CURRENTLY HAVE A LAWYER? YES NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF LAWYER: ____

PHONE #: ______________________ FAX #: ______________________

EMAIL: ______________________

ARE YOU REQUIRED TO ATTEND COURT, IF YES, PLEASE PROVIDE DATE, TIME, AND A COPY OF THE ORDER:

____

WERE ANY MIND-ALTERING SUBSTANCES INVOLVED DURING YOUR LEGAL PROBLEMS? YES NO

IF YES, PLEASE EXPLAIN: ____

____

HAVE YOU EVER BEEN INVOLVED OR HAD ANY CURRENT GANG INVOLVEMENT? YES NO UNKNOWN

- **ALL INFORMATION PERTAINING TO CURRENT LEGAL MATTERS AND PROBATION ORDERS ARE REQUIRED TO BE FORWARDED WITH THE REFERRAL PACKAGE.**
- **NO REFERRAL WILL BE CONSIDERED UNTIL ALL DOCUMENTS ARE OBTAINED.**
- **CRITICAL INFORMATION THAT IS WITHHELD, FALSE, MISLEADING, OR FABRICATED MAY RESULT IN DISCHARGE, ESPECIALLY IN THE EVENT WHERE THE SAFETY OF OTHERS IS AT RISK.**

E. FAMILY HISTORY

DO YOU HAVE ANY DEPENDENT CHILDREN? YES NO

IF YES, WILL THEY HAVE ACCESS TO ADEQUATE CHILDCARE WHILE YOU ARE IN TREATMENT? YES NO

ARE THE CHILDREN IN CARE? YES NO

DO YOU HAVE OTHER DEPENDENTS? YES NO

WHAT IS YOUR CURRENT LIVING SITUATION? (*CHECK OFF ALL THAT APPLY)*:

ON-RESERVE	IMMEDIATE FAMILY	GROUP HOME
OFF-RESERVE	EXTENDED FAMILY	SHELTER
URBAN	LIVES ALONE	FOSTER CARE
RURAL	HOMELESS	COMMON LAW
		FRIEND

HAS THERE OR IS THERE CURRENTLY ANY CHILD WELFARE INVOLVEMENT? YES NO UNKNOWN

HAS ANYONE IN YOUR FAMILY OR COMMUNITY RECEIVED TREATMENT FOR SUBSTANCE USE? YES NO

IF YES, PLEASE EXPLAIN: ____

F. EDUCATION

ARE YOU CURRENTLY ATTENDING SCHOOL? YES NO

HIGHEST GRADE COMPLETED: ____________________________________

NAME OF LAST SCHOOL ATTENDED: ____

LAST YEAR ATTENDING THIS SCHOOL: _______________________

SCHOOL PHONE NUMBER AND/OR CONTACT INFORMATION: ____

DO YOU HAVE ANY SPECIAL NEEDS, LEARNING DISABILITIES, OR BEHAVIOURAL PROBLEMS THAT WE NEED TO BE AWARE OF? YES NO

IF YES, PLEASE EXPLAIN: ____

G. MEDICAL HISTORY

DO YOU HAVE ANY MEDICAL CONDITIONS? YES NO

IF YES, PLEASE IDENTIFY: ____

FAMILY DOCTOR'S NAME & PHONE NUMBER (if applicable): ____

PLEASE PROVIDE THE DATES OF YOUR LAST APPOINTMENTS FOR EACH OF THE FOLLOWING (approximately):

MEDICAL: ____

DENTAL: ____

OPTICAL: ____

DO YOU HAVE ANY ALLERGIES? YES NO

IF YES, PLEASE LIST ANY ALLERGIES AND THE REACTION TO THE ALLERGY:

____

____

PLEASE LIST ANY MEDICAL NEEDS WHILE ATTENDING PROGRAM:

____

____

ARE YOU CURRENTLY ON ANY MEDICATION? YES NO

Please ensure the Medical Assessment (PART 2) is completed by a Health Professional and attached to this application form.

H. SUBSTANCE USE HISTORY

AT WHAT AGE DID YOU START DRINKING ALCOHOL? ___________ NOT APPLICABLE

AT WHAT AGE DID YOU START TAKING OTHER DRUGS? ___________ NOT APPLICABLE

AT WHAT AGE DID YOU START USING SOLVENTS? ___________ NOT APPLICABLE

HAVE YOU EVER GOTTEN INTO ANY PHYSICAL FIGHTS WHILE USING? YES NO

HAVE YOU EVER CAUSED SERIOUS INJURY TO SELF OR OTHERS WHILE USING? YES NO

IF YES, PLEASE EXPLAIN: ____

DO YOU REQUIRE A WITHDRAWAL MANAGEMENT PLAN BEFORE YOU ATTEND THE PROGRAM?

____

HAVE YOU BEEN IN PREVIOUS TREATMENT FOR YOUR USE OF SUBSTANCES? YES NO

IF YES, PLEASE INDICATE WHERE, WHEN, HOW LONG YOU STAYED IN THE PROGRAM, AND THE REASON FOR DISCHARGE: ____

____

HAVE YOU PARTICIPATED IN A NON-RESIDENTIAL / COMMUNITY BASED SUBSTANCE USE AND/OR MENTAL HEALTH PROGRAM? YES NO

IF YES, PLEASE LIST THE TYPES OF PROGRAM(S): ____

____

I. PSYCHOLOGICAL FUNCTIONING

HAVE YOU EVER SPOKEN OR WRITTEN ABOUT KILLING YOURSELF? YES NO

HAVE YOU EVER ATTEMPTED TO KILL YOURSELF? YES NO

IF YES, HOW MANY TIMES AND HOW LONG AGO? ____

HOW DID YOU ATTEMPT TO KILL YOURSELF? ____

HAVE YOU EVER TAKEN PART IN SELF-HARMING BEHAVIOURS? IF YES, PLEASE EXPLAIN:

____

DO YOU HAVE DIFFICULTLY WITH ANGER? IF YES, PLEASE EXPLAIN: ____

____

DO YOU REQUIRE BEHAVIOURAL MANAGEMENT? IF YES, PLEASE EXPLAIN: ____________________________________

____

HAVE YOU EVER DEMONSTRATED CRUELTY TO ANIMALS? IF YES, PLEASE EXPLAIN: ___________________________________

____

DO YOU HAVE A HISTORY OF AGGRESSION TOWARDS OTHERS? IF YES, PLEASE EXPLAIN: ______________________________

____

DO YOU HAVE A HISTORY OF FIRE SETTING? IF YES, PLEASE EXPLAIN: ____

____

DO YOU HAVE A HISTORY OF DESTROYING PROPERTY? IF YES, PLEASE EXPLAIN: ______________________________________

____

IS THERE ANY KNOWN HISTORY OF SEXUAL ABUSE? YES NO UNKNOWN

IS THERE ANY KNOWN HISTORY OF PHYSICAL ABUSE? YES NO UNKNOWN

IS THERE ANY KNOWN HISTORY OF EMOTIONAL ABUSE? YES NO UNKNOWN

IS THERE ANY HISTORY OF FAMILY VIOLENCE THAT YOU MAY HAVE BEEN WITNESS TO?

YES NO UNKNOWN

HAVE YOU EVER HAD ANY PSYCHOLOGICAL TESTING OR COUNSELLING? YES NO

IF YES, FOR WHAT PURPOSE? ____

____

Please attach any psychological / mental health assessment(s) conducted to-date (i.e., psycho-educational, SASSI, MAST, DAST, etc.).

PLEASE INDICATE WHETHER YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS OR SPECIFY IF ANY OTHER DIAGNOSES:

DISORDER	DIAGNOSED
FETAL ALCOHOL SPECTRUM DISORDER (FASD)	
OPPOSITIONAL DEFIANT DISORDER (ODD)	
CONDUCT DISORDER (CD)	
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)	
ATTENTION DEFICIT DISORDER (ADD)	
OTHER:	

WHEN IN A SOBER STATE…

HAVE YOU COMMUNICATED WITH SPIRITS NO ONE ELSE CAN SEE OR HEAR?

NONE OF THE TIME SOME OF THE TIME

MOST OF THE TIME ALL OF THE TIME

ARE THESE ENCOUNTERS POSITIVE OR NEGATIVE EXPERIENCES FOR YOU?

POSITIVE NEGATIVE INDIFFERENT

ARE THERE TIMES WHEN PEOPLE ARE UNABLE TO COMMUNICATE WITH YOU?

NONE OF THE TIME SOME OF THE TIME

MOST OF THE TIME ALL OF THE TIME

PLEASE EXPLAIN: ____

J. OUTSIDE RESOURCES

ARE THERE ANY OTHER AGENCIES IN YOUR CIRCLE OF CARE? YES NO

IF YES, WHICH AGENCIES AND WHAT SERVICES DO THEY PROVIDE? (i.e., NNADAP, CHR, CFS):

NAME OF AGENCY / RESOURCE PERSON	DESCRIPTION OF SUPPORT	CONTACT INFORMATION

K. CLOTHING INFORMATION

THIS INFORMATION IS FOR STAFF TO ENSURE YOU HAVE THE PROPER APPAREL FOR LAND-BASED ACTIVITIES AND TO ASSIST WITH REPLACEMENT IF SOMETHING HAS BEEN DAMAGED DURING YOUR STAY.

PLEASE PROVIDE US WITH YOUR CLOTHING SIZES BELOW:

SHIRT SIZE: ______________________ PANT SIZE: _______________________ SHOE SIZE: _____________

BRA SIZE (if applicable): _______________ UNDERWEAR SIZE: _________________