



Walgwan Admission Request

Documents to be sent

A) Please complete the following material

Admission Request Form	<input type="checkbox"/>	Consent to Nicotine Patches	
Consent to Care Form	<input type="checkbox"/>	Commitment to Care Form	<input type="checkbox"/>
Activity Consent Form	<input type="checkbox"/>	Consent to disclose and obtain information	<input type="checkbox"/>
Consent to Immunization	<input type="checkbox"/>	Consent to Video Monitoring	<input type="checkbox"/>
Procedures for AWOL	<input type="checkbox"/>	Other Clinical Reports if available	<input type="checkbox"/>

B) Please ensure that all following documents are included and signed by the required parties

	Is included	Will follow	Is not available
Scholastic info & School Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Info on consumption of substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Court Order/Alternative Measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consent Form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Care Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (reports from previous treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivation letter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB Test results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ensure that the minimal clothing inventory has been completed, indicating the client will be admitted with all required clothing.

If you have any additional information you think would be helpful, or if you require more room than there is on the forms, please attach additional pages.

C) Mail, email or fax the above material to the attention of:

Kayla Gedeon
 Centre Walgwan Center
 75 School Street
 Gesgapegisag (Québec) G0C 1Y1

kayla@walgwan.com
 Phone: 418 759-3006
 Fax: 418 759-3064

Questions in **RED** on this form are mandatory.

PLEASE NOTE THAT ALL SECTIONS MUST BE FILLED. INCOMPLETE APPLICATIONS MAY BE RETURNED, THUS DELAYING THE ADMISSION PROCESS. The form must be completed by the referral agent. Do not hesitate to attach additional sheets if necessary. After saving this document, please send it to kayla@walgwan.com

Please take note that due to the current pandemic situation of COVID-19 family visits will not take place during the duration of the treatment program; however, efforts will be made to maintain contact via social media outlets. The escort will be permitted to enter the Walgwan Center upon arrival of the youth wearing the proper PPE and participate in the welcoming interview but will not be permitted to stay thereafter. For a program completion, only one escort will be permitted to participate in the events (i.e. meetings with primary counsellor and recognition ceremony) and must wear the proper PPE.

*PPE provided by the Walgwan Center

Client Information									
Date Application Received by Community Worker:					Date Application Received by Treatment Centre:				
Surname:			First Name:		Nickname:				
Date of Birth:		Age:	Sex:	Provincial Health Card Number:					
Client Address:					Client Phone:				
Language Spoken:			Language Preferred:		Language Understood:				
Status Indian:			Treaty Number:		Band Name:				
Biological Parents:									
Guardian Name:			Guardian Address:				Guardian Phone:		
Place of Employment:					Phone:				
Social Services Involvement									
Agency Name:					Phone:				
Worker Name:					Client Status:				
Child Welfare Involvement:									
Family/Relationships									
Does client have dependant children?									
If yes, do they have access to adequate childcare while in treatment?									
Are the children in care?									
Does the client have other dependants?									
Provide information on client's children or other dependants:									
Name			Age			Relationship			
Who does your client live with?					Who does your client feel closest to?				
How does your client get along with his/her family members?									
Does client have any siblings?									
Name			Age		Health Status		Lives With		
Maternal									
Paternal									
Does your client have any close friends?					If so, who?				
Does he/she have a girlfriend or boyfriend?					Is he/she sexually active?				
Does he/she talk to any elders?					Is he/she willing to listen?				
Religious Beliefs									
Other Beliefs									
Family Supports:									
Family Strengths:									

Education			
Does your client go to school?		Does your client like school?	
Highest grade completed?			
Name of school:		Last year attending this school	
Medical History			
Does your client have any medical problems?		Does he/she require a medical consent form?	
Please identify:			
Family doctor's name and phone number:			
Is your client currently on any medication?		Does he/she have any allergies?	
Legal Problems			
Has your client ever been in trouble with the law?			
Please explain:			
Legal System Involvement:			
Was alcohol or any other substances; such as 'sniff' or drugs involved during your client's legal problems?			
Please explain:			
Is your client currently on probation or on a court order?			
Name of probation officer:		Phone:	Fax Number:
Probation Order		From:	To:
Conditions:			
Copy Attached?	Has your client been involved with any Solvents/Substance Abuse?		
Gang Involvement:			
Psychological Functioning			
Has your client ever spoken or written about killing him/her self?		Has your client ever attempt to kill him/her self?	
How many times?			
How did he/she attempt to kill him/her self?			
Has the client frequently gone off on their own when he/she is depressed or unhappy?		Is the client sad/unhappy?	
How often is the client sad/unhappy?			
Is there any known history of sexual abuse?		Is there any known history of physical abuse?	
Is there any known history of emotional abuse?			
Please explain: (i.e. at what age, has it been reported and what is the outcome or current status)			
Is there any history of family violence that this child may have been witness to?			
Please explain:			
When the client is in a sober state has he/she communicated with spirits that no one else can see or hear?			
Are these communications positive or negative experiences for the client?			
Please explain:			
Are there times when people are unable to communicate with the client?			
Please explain:			
Has your client ever had any psychological testing or counseling?			
If so, for what purpose?			
Self-harming Behaviour(s):			

Outside Resources	
Are there any other agencies involved with your client and his/her family?	
If so, which ones and what services do they provide? (for example, NNADAP, CHR, CFS)	
Family Activities/Practices: (What do you see as a family?)	
Family Roles/Relationships: (How do they interact with each other?)	
Status in the Community: (How is the family perceived in the community?)	
What type of belief system is practiced?	
How does he/she spend his/her leisure time?	
Who are the other support people involved with the family? (example; elders, extended family, community groups, community workers, CHR, NNADAP, CWPW)	
Is the client aware of the effects of solvents/substances?	
Is the client's family aware of the effects of solvents/substances?	
Is the client's community worker aware of the effects of solvents/substances?	
Does the family believe the client recognizes that he/she has a problem?	
What steps does the family want to take to address the problem?	
Has anyone in his/her family or community received treatment for solvent/substance abuse?	
Please explain:	
Are the parent(s) supportive of their child receiving treatment? (refer to Referral Agent Agreement and Parental Consent Form)	
Please explain:	
Upon the child's completion of the program, what type of support system do you see as effective/useful to help maintain a clean lifestyle for self/child?	
Are the extended family members supportive of the family seeking help and/or treatment for themselves or their child?	
Please explain:	
Would the family be willing to come to our Treatment Centre to observe the program in action as part of the intake process?	

Chemical History Use

Please indicate all known substances used by client

Gasoline	<input type="checkbox"/>	Butane	<input type="checkbox"/>	Cleaning fluids	<input type="checkbox"/>	Diesel fuel	<input type="checkbox"/>		
Nail Polish	<input type="checkbox"/>	Cement	<input type="checkbox"/>	Hair Spray	<input type="checkbox"/>	Paint remover	<input type="checkbox"/>		
Propane	<input type="checkbox"/>	Deodorants	<input type="checkbox"/>	Typewriter correction fluid	<input type="checkbox"/>	Nail polish remover	<input type="checkbox"/>		
Glue	<input type="checkbox"/>		<input type="checkbox"/>	Room deodorizer	<input type="checkbox"/>	Spray Paint	<input type="checkbox"/>		
Prescribed Medication				<input type="checkbox"/>	Over the counter drugs				<input type="checkbox"/>
Specify which ones				Which ones? (Tylenol, cough syrup)					
Alcohol	<input type="checkbox"/>	Marijuana, <i>Weed</i> or Hashish	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	PCP	<input type="checkbox"/>	LSD	<input type="checkbox"/>
Other, specify:									
List substances used in order of preference									
Substance	Date		Frequency of use	Quantity consumed					
	Frist Use	Last use							
Did the client's use of substances increase over time?									
At what age did the client use the most?									
What elements trigger use of substances?									

What are the reasons given by the client for using substances?

- | | | | | | |
|-----------------------------|--------------------------|---------------------------------|--------------------------|-----------------------|--------------------------|
| To make friends | <input type="checkbox"/> | To be part of a group | <input type="checkbox"/> | To do like my friends | <input type="checkbox"/> |
| Because nobody likes me | <input type="checkbox"/> | Because nobody takes care of me | <input type="checkbox"/> | To have fun | <input type="checkbox"/> |
| To forget about my problems | <input type="checkbox"/> | Because nobody understands me | <input type="checkbox"/> | Other | <input type="checkbox"/> |

Has the client ever experienced a period of abstinence? _____
 If so, explain when this period occurred and how long it lasted

What methods did the client use in order to reach that level of abstinence at the time?

Indicate the effects that using substances has on the client's life.

- | | | | | | |
|--------------------|--------------------------|--------------------------------------|--------------------------|----------------------------------|--------------------------|
| Loss of friends | <input type="checkbox"/> | Suspension from school | <input type="checkbox"/> | Aggressive behaviour | <input type="checkbox"/> |
| Feelings of regret | <input type="checkbox"/> | Arrest for committing an illegal act | <input type="checkbox"/> | Feelings of shame | <input type="checkbox"/> |
| Loss of appetite | <input type="checkbox"/> | Experienced a blackout | <input type="checkbox"/> | Forgetting what happened | <input type="checkbox"/> |
| Feelings of guilt | <input type="checkbox"/> | Made a suicide attempt | <input type="checkbox"/> | Being afraid without knowing why | <input type="checkbox"/> |

- Having to be taken to the hospital Became sick after stopping for a couple of days
 - Experienced hallucinations Having been in dangerous situations or in an accident
 - Hurt somebody you care about Conflict with family or significant others
- Comments: _____

At what age did the client start sniffing? _____

At what age did the client start drinking alcohol? _____

At what age did the client start using other drugs? _____

Does anyone else in the family use solvent/substances? _____

If so, who else? _____

Does client use solvent/substances with others or by him/herself? _____ Does client usually sniff or use at home? _____

Does client usually sniff or use at a friend's house? _____ Does client usually sniff or use at school? _____

Does client usually sniff or use in an abandoned building? _____ Does client usually sniff or use in an abandoned car or truck? _____

Does client usually sniff or use at a party? _____ Does client usually sniff or use outdoor? _____

Is there any other place your client usually sniffs or uses? _____

Has your client ever lost friends because of sniffing or using? _____

Has your client ever gotten into any physical fights when using? _____

Has your client ever caused serious injuries to others? _____

Please explain: _____

Does he/she feel that they have control over their use of solvents/substances? _____

Has he/she ever considered reducing or quitting? _____

Has he/she ever been in any previous treatment for their use of solvents/substances? _____

If so, where have they had previous treatment? _____

When have they had previous treatment? _____

How long did the client stay in the program? (In months) _____

Has the client participated in a non-residential/community-based substance abuse and/or mental health program? _____

If yes, what type of program? _____

Medical Information

CLIENT'S MEDICAL INFORMATION

This section should be filled out by doctor or a nurse

Identification of physician (or nurse):

Name of Clinic: _____
Name of Medical Examiner: _____ Title: _____
Postal Code: _____ Telephone: _____

Client's information:

Name: _____
Client's file number: _____ Health Insurance #: _____
BP: _____ Weight: _____ Height: _____

Are immunizations up to date? Yes No Unknown
If not, what is presently required? _____

If appropriate indicate:

Date of the last menstrual period: _____

Is client pregnant? Yes Non If yes, how many weeks? _____

Physical Examination by: _____

Date of exam: _____

	Normal	Abnormal	Specify
<input type="checkbox"/> Gastro-intestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Genito-urinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Reticula-endothelial	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Blood, lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Ear, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Hair, skin, nails	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other health problems

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Enuresis | <input type="checkbox"/> Learning problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Coordination problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> STD | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Mental deficit |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Difficulty in concentrating | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Poor hygiene |
| <input type="checkbox"/> Lice and nits | | | |

Date of test for TB _____

Please include the results

Please note that if the client is currently on prescribed medication, he must arrive at the Center with the written prescription. We will then make sure to submit the prescription to the pharmacy to get his/her medications.

Give details about the problems and treatment, if necessary:

Medical Information related to COVID-19

Do you have a concern for a potential COVID-19 infection for the person (e.g. is there an outbreak in the community, is the patient awaiting COVID-19 test results, etc.)? _____

Did the person travel outside of Canada in the past 14 days? _____

Has the person tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? _____

Does the person have any of the following symptoms?

- Fever _____
- New onset of cough _____
- Worsening chronic cough _____
- Shortness of breath _____
- Difficulty breathing _____
- Sore throat _____
- Difficulty swallowing _____
- Decrease or loss of sense of taste or smell _____
- Chills _____
- Headaches _____
- Unexplained fatigue/malaise/muscle aches (myalgias) _____
- Nausea/vomiting, diarrhea, abdominal pain _____
- Pink eye (conjunctivitis) _____
- Runny nose or nasal congestion without other known cause _____

COVID-19 Screening Results

If response to **ALL** of the screening questions is **NO**: COVID Screen **Negative**

If response to **ANY** of the screening questions is **YES**: COVID Screen **Positive**

Consent to Care Form

I, _____ on this date _____
(Parent /Legal Guardian) (Today's date – dd / mm / yy)
authorize the Executive Director of Centre Walgwan Center or his delegate to provide rehabilitation treatment for

(Name of Client) (Date of birth)

For a period of:

- Whole program (14 weeks)**
- Prevention Program (4 weeks)**

I understand that I am also:

- Consenting to psychological or psychiatric assessment
- Consenting to medical assessment and treatment
- Allowing the Center to transmit & receive personal information concerning the clinical files to and from:
Social Services, Psychological Services, N.A.A.D.A.P. Worker, Youth Center
Psychiatric Services, Schools, and others as required.

I understand that no information will be released to any other person without my written consent except to persons directly involved with my treatment.

I can withdraw or amend my consent to the release of information at any time.

Signature of the client _____

Signature of the parent _____

Or Legal Guardian

Signature of the referent _____

Start date of consent _____ End date of consent _____

(30 days after treatment)

Commitment to care

Walgwan is a 12 bed facility for youth ages 12-17 seeking to provide cultural and therapeutic treatment for First Nations, Inuit and Metis youth, expressing a need for support. As a client, referral, parent, guardian or other significant person, you play an integral part throughout the 14 week program or 6 week prevention program.

This form is a statement of what you are committing to:

Youth/client:

1. What are your goals for attending treatment?

2. Are you willing to revise these goals at the halfway point?
 yes no

Referral:

1. Will you call consistently to check on the progress of your client and provide support?
 yes no
2. Are you available to receive updates from primary counsellors bi-weekly?
 yes no
3. Are you willing to play an active role in the client's treatment plan?
 yes no
4. Are you available and willing to provide follow up services after treatment completion?
 yes no

Family or significant person:

1. Will you call consistently to check on the progress of your child and provide support?
 yes no
2. Are you available to receive updates from primary counsellors bi-weekly?
 yes no
3. Are you willing to play an active role in your child's treatment plan?
 yes no
4. Are you willing to work in collaboration with Walgwan by following through on recommendations and referrals after treatment?
 yes no

5. Are you able to be present for family visits mid-program and completion of program (consists of participating in family circles)?

___ yes ___ no

As those significant people involved, we commit to the answers provided in the above page in the commitment to care.

- As the **youth/client**, I am committing to a 14 week program or 6 week prevention program and my treatment goals.

Signature: _____ Date: _____

- As the **referral**, I am committing to play an active role in pre-treatment (admission process), during treatment and thereafter.

Signature: _____ Date: _____

- As **family or a significant person**, we/I are/am committing to playing an active role in pre-treatment (admission and intake), during treatment and thereafter in supporting my child, following through on recommendations and being present for visits and family circles.

Signature: _____ Date: _____

Consent to Wearing Nicotine Patches

Policy on Smoking Cigarette

It is forbidden to smoke at Walgwan. Upon admission to Walgwan, the youth cannot have cigarettes, lighters or matches on them at any time. Smokers who enter Walgwan will be strongly encouraged to participate in a program to quit smoking as part of their treatment program. Thus, any youth older than 14 years can be supplied with and use nicotine patches with the consent of their parents or their legal guardians.

Please sign the following Consent Form:

As a parent or legal guardian, I consent to allow my youth to obtain and wear nicotine patches:

Parent or Guardian _____ Youth _____
Date _____

I agree to obey the above rule.

Signature of Client _____

Date: _____

Consent to Disclose and to Obtain Information¹

I, the undersigned _____

Born on: _____

Consent that _____

(Name of the institution, organization or professional, or name and qualification of the person)

Disclose the following information or documents:

To: _____

(Name of the institution, organization or professional, or name and qualification of the person)

Obtain the following information or documents:

From: _____

(Name of the institution, organization or professional, or name and qualification of the person)

Contained in the file of:

Family Name

Given Name

Date of Birth

Address (Number, street, city, postal code)

For the following reasons:

(Specify the reasons for the disclosure)

This consent may be withdrawn at any time.

Signed at _____, this _____

(day/month/year)

Signature

Witness' signature and name in block letters

¹ Note: This form must be signed by:

- a client of 14 years or older
- a person exercising parental authority if the client is less than 14 years old

Consent to Disclose and to Obtain Personal Education Information²

I, the undersigned _____

Born on: _____

Consent that Centre Walgwan Center, Lucy J Casey-Campbell (teacher)
(Name of the institution, organization or professional, or name and qualification of the person)

Disclose the following information or documents:

To: _____
(Name of the institution, organization or professional, or name and qualification of the person)

Obtain the following information or documents:

-Copy of my school file _____

-Any work that should be completed if possible, during my stay at the Walgwan Center _____

From: _____
(Name of the institution, organization or professional, or name and qualification of the person)

Contained in the file of:

Family Name _____

Given Name _____

Date of Birth _____

Address (Number, street, city, postal code) _____

For the following reasons:

-To establish an Individual Education Plan during my stay at the Walgwan Center _____

(Specify the reasons for the disclosure)

This consent may be withdrawn at any time.

Signed at _____, this _____
(day/month/year)

Signature _____

Witness' signature and name in block letters

² Note: This form must be signed by:

- A client of 14 years or older
- A person exercising parental authority if the client is less than 14 years old.

Consent to Immunization

I, _____ hereby consent to the influenza vaccination for
(Parent/Guardian's Name)

for _____
(Youth's Name)

while in treatment at Centre Walgwan Center in accordance with the Occupational Health and Safety Standards.

I understand that only a qualified medical professional shall administer the vaccination.

(Parent/Guardian's Signature)

Date: _____

Consent to Video Monitoring

The Centre Walgwan Center uses, "Video Monitoring" as an enhancement to the safety and security of the clients and its facilities. Confidentiality is maintained; however, videos may be shared in the case of criminal investigations.

I, _____ (Parent/Guardian) understand that video monitoring at Centre Walgwan Center is used for the safety and security of my child, and consent to video monitoring.

Signature

Date

Absent without Leave Procedure Form

Client's Name: _____ Alias: _____

Date of Birth: _____ Tattoos/Scars _____

Are there any court orders currently in effect? Yes No

If yes, what is the status and who is the contact person?

Physical Description	Insert Client's Picture
Hair color: _____	<div style="border: 1px solid black; height: 150px; width: 100%;"></div>
Eye color: _____	
Height: _____	
Weight: _____	

Notification Procedure:

Referral Agent is to be notified

- Immediately
- After 4 hours
- After 8 hours

Parents/Guardian are to be notified:

- Immediately
- After 4 hours
- After 8 hours

In the event that Parents/Guardians are not available, the following people may be notified:

Name: _____ Name: _____

Address: _____ Address: _____

Phone # _____ Phone # _____

Relationship _____

Relationship _____

**** I understand the Centre Walgwan Center will make every attempt to ensure the safety of my child at all times. In the event of an AWOL, I understand the Center's personnel will allow enough time for my child to return to the Center. Any unplanned leave that is longer than four hours will be considered an "AWOL," and will be followed up by a formal report to the referral agent.**

Referral Agent's Signature _____

Parent/Guardian's Signature _____