Walgwan Admission Request

Documents to be sent

A) Please complete the following material

Admission Request Form	☐	Consent to Nicotine Patches	☐
Consent to Care Form	☐	Commitment to Care Form	☐
Activity Consent Form	☐	Consent to disclose and obtain information	☐
Consent to Immunization	☐	Consent to Video Monitoring	☐
Procedures for AWOL	☐	Other Clinical Reports if available	☐

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	○	○	○
Info on consumption of substances	○	○	○
Court Order/Alternative Measures	○	○	○
Consent Form	○	○	○
Medical Report	○	○	○
Health Care Card	○	○	○
Family information	○	○	○
Others (reports from previous treatment)	○	○	○
Motivation letter	○	○	○
TB Test results	○	○	○

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

admission@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 admission@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: Select	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:	Select Status
Child Welfare Involvement:	Select answer		

Family/Relationships	
Does client have dependant children?	Select answer
If yes, do they have access to adequate childcare while in treatment?	Select answer
Are the children in care?	Select answer
Does the client have other dependants?	Select answer

Provide information on client's children or other dependants:

Name	Age	Relationship

Who does your client live with?	Select answer	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?	Select answer	If so, who?	
Does he/she have a girlfriend or boyfriend?	Select answer	Is he/she sexually active?	Select answer
Does he/she talk to any elders?	Select answer	Is he/she willing to listen?	Select answer
Religious Beliefs	Select answer		

Other Beliefs

Family Supports:

Family Strengths:

Education			
Does your client go to school?	Unknown	Does your client like school?	Select answer
Highest grade completed?			
Name of school:		Last year attending this school	

Medical History			
Does your client have any medical problems?	Select answer	Does he/she require a medical consent form?	Select answer
Please identify:			
Family doctor's name and phone number:			
Is your client currently on any medication?	Select answer	Does he/she have any allergies?	Select answer

Legal Problems					
Has your client ever been in trouble with the law?					Select answer
Please explain:					
Legal System Involvement:	Select answer				
Was alcohol or any other substances; such as `sniff` or drugs involved during your client`s legal problems?					Select answer
Please explain:					
Is your client currently on probation or on a court order?					Select answer
Name of probation officer:		Phone:		Fax Number:	
Probation Order	From:		To:		
Conditions:					
Copy Attached?	Select answer	Has your client been involved with any Solvents/Substance Abuse?			Select answer
Gang Involvement:	Select answer				

Psychological Functioning			
Has your client ever spoken or written about killing him/her self?	Select answer	**Has your client ever attempt to kill iim/ her self?**	Select answer
How many times?	Select answer		
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?	Select answer	Is the client sad/unhappy?	Select answer
How often is the client sad/unhappy?	Select answer		
Is there any known history of sexual abuse?	Select answer	**Is there any known history of physical abuse?**	Select answer
Is there any known history of emotional abuse?	Select answer		
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?			Select answer
Please explain:			
When the client is in a sober state has he/she communicated with spirits that no one else can see or hear?			Select answer
Are these communications positive or negative experiences for the client?			Select answer
Please explain:			
Are there times when people are unable to communicate with the client?			Some of the time
Please explain:			
Has your client ever had any psychological testing or counseling?			Select answer
If so, for what purpose?			
Self-harming Behaviour(s):	Select answer		

Outside Resources	
Are there any other agencies involved with your client and his/her family?	Select answer
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?	Select answer
Is the client's family aware of the effects of solvents/substances?	Select answer
Is the client's community worker aware of the effects of solvents/substances?	Select answer
Does the family believe the client recognizes that he/she has a problem?	Select answer
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?	Select answer
Please explain:	
Are the parent(s) supportive of their child receiving treatment? (refer to Referral Agent Agreement and Parental Consent Form)	Select answer
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?	Select answer
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?	Select answer

Please list three of client's preferred meal:

Chemical History Use

Please indicate all known substances used by client

Gasoline	☐	Butane	☐	Cleaning fluids	☐	Diesel fuel	☐
Nail Polish	☐	Cement	☐	Hair Spray	☐	Paint remover	☐
Propane	☐	Deodorants	☐	Typewriter correction fluid	☐	Nail polish remover	☐
Glue	☐		☐	Room deodorizer	☐	Spray Paint	☐

Prescribed Medication	☐	Over the counter drugs	☐
Specify which ones		Which ones? (Tylenol, cough syrup)	

Alcohol	☐	Marijuana, *Weed* or Hashish	☐	Cocaine	☐	PCP	☐	LSD	☐

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	☐	To be part of a group	☐	To do like my friends	☐
Because nobody likes me	☐	Because nobody takes care of me	☐	To have fun	☐
To forget about my problems	☐	Because nobody understands me	☐	Other	☐

Has the client ever experienced a period of abstinence? Select answer

If so, explain when this period occurred and how long it lasted

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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	☐	Suspension from school	☐	Aggressive behaviour	☐
Feelings of regret	☐	Arrest for committing an illegal act	☐	Feelings of shame	☐
Loss of appetite	☐	Experienced a blackout	☐	Forgetting what happened	☐
Feelings of guilt	☐	Made a suicide attempt	☐	Being afraid without knowing why	☐

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? Select answer
If so, who else? _____
Does client use solvent/substances with others or by him/herself? Select answer
Does client usually sniff or use at home? Select answer
Does client usually sniff or use at a friend's house? Select answer
Does client usually sniff or use at school? Select answer
Does client usually sniff or use in an abandoned building? Select answer
Does client usually sniff or use in an abandoned car or truck? Select answer
Does client usually sniff or use at a party? Select answer
Does client usually sniff or use outdoor? Select answer
Is there any other place your client usually sniffs or uses? _____
Has your client ever lost friends because of sniffing or using? Select answer
Has your client ever gotten into any physical fights when using? Select answer
Has your client ever caused serious injuries to others? Select answer
Please explain: _____
Does he/she feel that they have control over their use of solvents/substances? Select answer
Has he/she ever considered reducing or quitting?
Has he/she ever been in any previous treatment for their use of solvents/substances? Select answer
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? Select answer
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
☐ Gastro-intestinal	☐	☐	
☐ Genito-urinary	☐	☐	
☐ Respiratory	☐	☐	
☐ Cardiovascular	☐	☐	
☐ Musculoskeletal	☐	☐	
☐ Reticula-endothelial	☐	☐	
☐ Blood, lymphatic	☐	☐	
☐ Abdomen	☐	☐	
☐ Thyroid	☐	☐	
☐ Appearance	☐	☐	
☐ Ear, nose, throat	☐	☐	
☐ Hair, skin, nails	☐	☐	

Other health problems

☐ Eating problems	☐ Sleeping problems	☐ Enuresis	☐ Learning problems
☐ Asthma	☐ Diabetes	☐ Epilepsy	☐ Coordination problems
☐ Allergies	☐ STD	☐ Hyperactivity	☐ Mental deficit
☐ Agitation	☐ Difficulty in concentrating	☐ Hallucinations	☐ Vision problems
☐ Hearing problems	☐ Poor memory	☐ Skin problems	☐ Poor hygiene
☐ Lice and nits			

Date of test for TB _____ Please include the results

Please note that if the client is currently on prescribed medication,* <u>he must arrive at the Center with the written prescription</u>*. 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.)? Select answer

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

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

Does the person have any of the following symptoms?

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

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**

What is the result?

Is Client vaccinated for COVID? Select

If so, date of first dose:

Date of second dose:

Mental Health

Does the client have mental health problems? Yes ☐ No ☐ Unknown ☐

If yes, please specify? ☐ Fears, distress ☐ Depression ☐ Suicidal Ideations ☐ Suicidal Attempts ☐ Paranoia ☐ Others:

Please provide information concerning the client's mental health problems, such as what triggered them, the dates and/or periods where they occurred, the duration, and methods used to control them, etc.

Is the client presently under the care of a professional? Yes ☐ No ☐

If yes, name of specialist: _____

Reason to follow-up:

Please provide the report of the specialist – Is report included? Yes ☐ No ☐

If the client is not under care, would you suggest a professional follow-up based on your evaluation?

Yes ☐ No ☐ If yes, for what reasons?

Medication

Does the client take medication? Yes ☐ No ☐ Unknown ☐ If yes, please list:

Medication	Start Date/End Date	Dosage	Reason

Dietary Restrictions:

Does the client have dietary restrictions? Yes ☐ No ☐ Unknown ☐ If yes, please list:

Please provide all other relevant medical information:

Date the client was seen: _____

Signature of the specialist: _____

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 your 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 Information[1]

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 Information[2]

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.

Activity Consent Form
Approval by Parents or Legal Guardian

The recommended use of this form is for the consent and approval for Walgwan clients, staff members, and volunteers (ex. elders) to participate in a trip or an activity (such as hunting, trapping, fishing, canoeing, camping, outdoor outings, etc.).

First Name _____ Middle Name _____ Last Name _____

Birth date _____ Age during activity _____

Address _____ City _____

Province _____ Postal code _____

Has my approval to participate in (name of activity, outing trip, etc.)

Name of activity _____

From (date) _____ To (date) _____

INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

I understand that participation in Centre Walgwan Center activities may involve the risk of personal injury.

I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving my child, I understand that efforts will be made to contact me. In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

With appreciation of the risks associated with programs and activities including preparations for and transportation to and from the activity, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Centre Walgwan Center, its administrators, supervisors and employees or volunteers, associated with any program or activity.

NOTE: Centre Walgwan Center cannot continually monitor compliance of its clients or any limitations imposed upon them by parents or medical providers. Please list any restrictions imposed on your child and counsel your child to comply with those restrictions.
In addition, during outdoor activities, third parties may take photos and videos. As we cannot control what these third parties will do with these photos and videos, the Center cannot be held responsible for breaches of the confidentiality of our clients by third parties.

List participant restrictions, if any:

_____

☐ None

_____ _____

Participant signature Date

_____

Parent/Guardian printed name

_____ _____

Parent/Guardian signature Date

Area Code and telephone number (Best contact and Emergency contact) _____

Email (for use in sharing more details about the trip or activity) _____

Contact the adult leader with any questions

_____ _____ _____

Name Phone Email

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.

_____ Date: _____
(Parent/Guardian's Signature)

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	
Hair color:	
Eye color:	
Height:	
Weight:	

Insert Client's Picture

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 _____