Walgwan Admission Request

Documents to be sent

A) Please complete the following material

Admission Request Form
Consent to Care Form

Commitment to Care Form
Consent to disclose and obtain information

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 (not necessary)	☐	☐	☐
Family information	☐	☐	☐
Others (reports from previous treatment)	☐	☐	☐
Motivation letter	☐	☐	☐

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) Click on the submit button to send.

Questions in **RED** on this form are mandatory. The submit button will not send the form until all required fields are answered.

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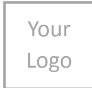
75 School Street Gesgapegiag
(Québec) G0C 1Y1

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



PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED.
INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS.
Form to be completed by the referring agent.
Questions in **red** are mandatory. If any information is not applicable indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

YSAC INTAKE/REFERRAL APPLICATION

Client Information			
Date Application Received by Community Worker		**Date Application Received by Treatment Centre**	
Surname:	**First Name:**	Nickname or other name known by:	
Date of Birth:	**Age:**	**Sex:**	**Provincial Health Card Number:**
Youth Address:	**Gender:**		**Youth Phone:**
Language Spoken:	**Language Preferred:**	Language Understood:	
Nation Status:		**Treaty Number (Band Number):**	
		Band Name:	
Biological Parents:			
Guardian Name:	**Guardian Phone:**	Guardian Address:	
Place of Employment:		Phone:	
Living Situation:			
Social Services Involvement			
Agency Name:		**Phone:**	
Worker Name:		Client Status:	
Child Welfare involvement:			

Family/Relationships

Does Client have dependent children?	
If yes, do they have access to adequate childcare while in treatment?	
Are the children in care?	
Does the client have other dependents?	

Provide information on client's children or other dependents:

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 the 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:	

Family Supports:

Family Strengths:

Education			
Does youth go to school?		Does your client like school?	
Highest grade completed:			
Name of school:		Last year attending this school:	
Medical History			
Does youth have any medical problems?		Does he/she require a medical consent form?	
Please identify:			
Family doctor's name:		Family doctor's phone number:	
Is your client currently on any medication?		Does he/she have any allergies?	
Legal Problems			
Has youth ever been in trouble with the law?			
Please explain:			
Legal System Involvement:		**Gang Involvement:**	
Was alcohol or any other substances, such as `sniff` or drugs involved during youth's legal problems?			
Please explain:			
Is youth currently on probation or on a court order?			
Name of probation officer:	Phone:	Fax:	
Probation Order: **From:**		**To:**	
Conditions:			
Copy Attached?		Has youth been involved with any Solvents/Substance Abuse?	
Chemical Use History			
At what age did youth start sniffing?		**At what age did youth start alcohol?**	
At what age did youth start using other drugs?		**Does anyone else in his/her family use solvents/substance?**	
If so, who else?			
Does he/she use solvents/substances with others or by him/herself?		Does youth usually sniff or huff at home?	
Does youth usually sniff or huff at a friend's house?		Does youth usually sniff or huff at school?	
Does youth usually sniff or huff in an abandoned building?		Does youth usually sniff or huff in an abandoned car or truck?	
Does youth usually sniff or huff at a party?		Does youth usually sniff or huff outdoors?	

Is there any other place youth usually sniffs or huffs?			
Has youth ever lost friends because of sniffing or huffing?		Has youth ever gotten into any physical fights when using?	
Has youth ever caused serious injury to other?			
Please explain:			
Does youth have any medical, physical, psychological, emotional problems because of the use of solvents/substances?			
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?			
Where have they had previous treatment?		When have they had previous treatment?	
How long did the youth stay in the program? (in months)			
Has youth participated in a non-residential/community-based substance abuse and/or mental health program?			
If yes, what type of program(s):			
Psychological Functioning			
Has youth ever spoken or written about killing him/herself?		**Has your youth ever attempted to kill him/herself**	
How many times?			
How did he/she attempt to kill him/herself?			
Has the youth frequently gone off on their own when he/she is depressed or unhappy?		Is the youth sad/unhappy?	
How often is the youth 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 youth 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 youth?			
Please explain:			

Are there times when people are unable to communicate with the youth?	
Please explain:	
Has youth 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 the youth 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 youth aware of the effects of solvents/substances?	
Is the youth's family aware of the effects of solvents/substances?	
Is the youth's community worker aware of the effects of solvents/substances?	
Does the family believe the youth 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:	

Chemical History Use Details

Please indicate all known substances used by the youth

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 youth's use of substances increase over time?		
At what age did the youth use the most?		
What elements trigger use of substances?		

What are the reasons given by the youth 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 youth ever experienced a period of abstinence? ____________________
If so, explain when this period occurred and how long it lasted

---

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

Indicate the effects that using substances has on the youth'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:

Medical Information

YOUTH'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: ____________________

Youth's information:

Name: ____________________

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

Date of test for TB ____________________ Please include the results

Please note that if the youth is currently on prescribed medication, he or she 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:

Mental Health

Does the youth have mental health problems? If yes, please specify. Yes ☐ No ☐ Unknown ☐

Fears, distress ☐Depression ☐ Suicidal Ideations ☐ Suicidal Attempts
☐ Paranoia ☐ Others:

Please provide information concerning the youth'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 youth 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 youth 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 youth take medication? Yes ☐ No ☐ Unknown ☐ If yes, please list:

Medication	Start Date/End Date	Dosage	Reason

Dietary Restrictions:

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

Please provide all other relevant medical information:

Date the youth 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 Youth (Date of birth)

For a period of:

☐ **Whole program (10 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 youth ______________________________

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 youth, 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:

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