Walgwan Admission Request

Please Select type of admission

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) 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.

Submit form by email.

Centre Walgwan Center
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:**
		Select	
Youth Address:	**Gender:**	Select	**Youth Phone:**
Language Spoken:	**Language Preferred:**	Language Understood:	
Select			
Nation Status:	Select	**Treaty Number (Band Number):**	
		Band Name:	
Biological Parents:			
Guardian Name:	**Guardian Phone:**	Guardian Address:	
Place of Employment:		Phone:	
Living Situation:	Select		
Social Services Involvement			
Agency Name:		**Phone:**	
Worker Name:		Youth Status:	
		Select Status	
Child Welfare involvement:	Select		

Family/Relationships

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

Provide information on client's children or other dependents:

Name	Age	Relationship

Who does the youth live with?	Select answer
Who does the youth feel closest to?	
How does the youth get along with his/her family members?	Select
Does the youth have any siblings?	Select

Name	Age	Health Status	Lives With
			Select
			Select
			Select
			Select
			Select
			Select
			Select
			Select
			Select

Maternal

Paternal

Does the youth 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
Religious Beliefs	Select	Other:	

Family Supports:

Family Strengths:

Education

Does youth go to school?	Select	Does the youth like school?	Select
Highest grade completed:			
Name of school:		Last year attending this school:	

Medical History

Does youth have any medical problems?	Select	Does he/she require a medical consent form?	Select answer
Please identify:			
Family doctor's name:		Family doctor's phone number:	
Is the youth currently on any medication?	Select	**Does he/she have any allergies?**	Select

Legal Problems

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

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?**	Select
If so, who else?			
Does he/she use solvents/substances with others or by him/herself?	Select	Does youth usually sniff or huff at home?	Select
Does youth usually sniff or huff at a friend's house?	Select	Does youth usually sniff or huff at school?	Select
Does youth usually sniff or huff in an abandoned building?	Select	Does youth usually sniff or huff in an abandoned car or truck?	Select
Does youth usually sniff or huff at a party?	Select	Does youth usually sniff or huff outdoors?	Select

Is there any other place youth usually sniffs or huffs?			
Has youth ever lost friends because of sniffing or huffing?	Select	Has youth ever gotten into any physical fights when using?	Select
Has youth ever caused serious injury to other?	Select		
Please explain:			
Does youth have any medical, physical, psychological, emotional problems because of the use of solvents/substances?			Select
Please explain:			
Does he/she feel that they have control over their use of solvents/substances?			Select
Has he/she ever considered reducing or quitting?			Select
Has he/she ever been in any previous treatment for their use of solvents/substances?			Select answe
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?			Select
If yes, what type of program(s):			
Psychological Functioning			
Has youth ever spoken or written about killing him/herself?	Select	**Has your youth ever attempted to kill him/herself**	Select answe
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?	Select	Is the youth sad/unhappy?	Select
How often is the youth sad/unhappy?	Select	**Is there any known history of sexual abuse?**	Select answe
Is there any known history of physical abuse	Select answe	**Is there any known history of emotional abuse?**	Select answe
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
Please explain:			
When the youth 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 youth?			Select
Please explain:			

Are there times when people are unable to communicate with the youth?	Select
Please explain:	
Has youth ever had any psychological testing or counseling?	Select answer
If so, for what purpose?	
Self-harming Behaviour(s):	Select
Outside Resources	
Are there any other agencies involved with the youth 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 youth aware of the effects of solvents/substances?	Select answer
Is the youth's family aware of the effects of solvents/substances?	Select answer
Is the youth's community worker aware of the effects of solvents/substances?	Select answer
Does the family believe the youth recognizes that he/she has a problem?	Select
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 abu	Select
Please explain:	
Are the parent(s) supportive of their child receiving treatment? (refer to Referral Agent Agreement and Parental Consent Form)	Select
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
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

Please list three of youth's favorite meals

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? Select answer

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	☐ 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 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
   ☐ ☐ 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 Youth _____

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

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 youth of 14 years or older
- A person exercising parental authority if the youth 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 youth 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

Youth'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 _____