SOUTH COUNTRY TREATMENT CENTRE

P.O. Box 1418, Lethbridge, AB T1J 4K2
Phone (403) 329-6603 Fax (403) 328-5756 www.southcountrytreatment.com

ADMISSION FORM

Any information not disclosed could result in your discharge from South Country Treatment Centre. **All appointments must be taken care of before you can be given an admission date, and no appointments will be allowed while in treatment. We are a non-medical facility, therefore any client presenting with a serious illness will not be able to attend treatment until all medical issues are resolved. If you have any pending court dates we cannot give you an admission date until these legal issues have been resolved. If you are on probation or have any legal paperwork, we need a copy of these faxed to us prior to giving you an admission date. South Country Treatment Centre reserves the right to refuse admission to clients it deems inappropriate for its programs.**

PART I IDENTIFICATION INFORMATION

First Name ___________ Middle Name:_______________ Last Name:____________

Address:___________________________ City/Town:_________________________

Province:_________Postal Code:____________E-Mail Address _____________________

Residence Telephone: ___________________Alternate Telephone: _________________

Date of Birth (MM/DD/YY) _________ Age:_____ Sex: Male Female Transgender

Marital Status: Single Married Divorced Separated Widowed Common-Law

Health Care #:_________________ Emergency Contact, Relationship & Phone #:

____

How did you hear about our services? Website Yellow Pages Friends/Family Referral Agency Former Client Other

If other please indicate below (i.e. Alberta Works/Income Support, Physician/Psychiatrist/Psychologist/Mental Health Worker, Employer, Legal)

____
____
____
____

PART II REFERRAL INFORMATION

Name of Referral (if any):____

Agency Telephone: _______________________Agency Fax: _______________________

Address:____

Details of any previous treatment for addictions:

Approximate Date	Where (Institution/Agency)	Reason for treatment

PART III HEALTH, MEDICAL AND LEGAL INFORMATION

Are you on any medication(s)? Yes No

If you are on medication please indicate below: (include herbal remedies, over the counter meds, laxatives, diet aids and vitamins)

Medication	Dosage	Frequency	Reason given	Start date

Have you experienced or been diagnosed with any of the following? (please check those that apply)

- Depression
- Anxiety/Panic attacks
- Bipolar
- Psychosis
- Substance-induced psychosis
- Schizophrenia
- Auditory or visual hallucinations
- Borderline Personality
- ADD and/or ADHD
- Post Traumatic Stress Disorder
- Fetal Alcohol Spectrum
- Suicide attempts/ideation
- Self Harm (cutting/burning)
- Learning disabilities

**** NOTE: CLIENT MUST BE ABLE TO READ, WRITE AND COMPREHEND ENGLISH IN ORDER TO ACCESS TREATMENT AT SOUTH COUNTRY TREATMENT CENTRE.**

Are you currently seeing a mental health therapist, psychiatrist or physician or have you seen one in the past? If so, please explain

____
____
____
____
____

Have you ever accessed any Persons with Developmental Disabilities (PDD) programing?
Yes No

Do you have any current health concerns such as listed below? (please check those that apply)

- Arthritis/Pain problems
- Asthma/Breathing problems
- Diabetes
- Epilepsy/Seizures
- Heart problems
- Hearing/Sight problems
- Hepatitis/Liver Disease
- HIV or AIDS
- Hypertension/ High cholesterol
- Influenza, cold etc.
- Scabies/Mites/Lice
- Sexually Transmitted Infection
- Staph infections
- Tuberculosis
- Sleeping issues/Snoring
- Trouble walking/Climbing stairs
- Cancer
- OTHER

If you have checked any of the above please explain:

____
____
____
____
____
____

Dietary/Allergy Issues: **South Country Treatment Centre does not cater to special dietary needs.**

Do you have any allergies to foods or medications? Yes No

If so, Please List

____

____

____

Legal Issues: Please document any of the following legal issues that apply to you. (Note: Clients on house arrest or curfews will not be accepted until these are lifted)

Out on bail	On Parole	Temporary Absence
Conditional Sentence Order	Recognizance	Statutory Release
Probation	Outstanding Warrants	Pending Court Dates
Child Welfare		

All probation orders, CSO's or recognizance papers must be sent to SCTC prior to intake

Please indicate the nature of the charges being dealt with:

____

____

____

____

If applicable please provide the name and contact information of your probation officer:

____

____

PART IV ALCOHOL/DRUG AND GAMBLING HISTORY

LIST THE DRUG OF CONCERN (i.e. Alcohol, marijuana, cocaine)	Date of last use M/D/Y	TYPE OF GAMBLING (i.e. VLT's, slots, internet, lotteries, gaming, betting)	Date last gambled M/D/Y

Please indicate any withdrawal symptoms (seizures, psychosis, fatigue etc.) you are currently experiencing or have experienced in the past: (if seizures please also include the last time this happened and the frequency.)

PART VI FINANCIAL INFORMATION

How will you be paying for your treatment? (please check the one that applies)

Certified cheque Money Order Bank Draft (all made out to South Country Treatment Centre)

3rd Party Payment Information:

Social Services (worker's name & phone #) ______________________________

AISH (worker's name & phone #) ______________________________

Employer: ____________________

Authorized by ____________________

Phone Number ____________________

Fax Number ____________________

Other Party Payment (party's name & phone #) ______________________________

Our Program Fees are 28 days @ $40/day which is $1120.00 (residents of Alberta); 28 days @$80/day which is $2240.00 (out-of-province residents).

NOTE: In the case of 3rd party payment for my treatment, I hereby authorize South Country Treatment Centre to release/obtain pertinent information related to my treatment to the above designated 3rd party.

NOTE: Financial arrangements to pay for program must be in place PRIOR to the client coming in.

By submitting this admission form, I acknowledge that all information provided is true and correct to the best of my knowledge. Failure to disclose complete and accurate information may result in the refusal of my application, or the termination of my involvement in programming at South Country Treatment Centre.

[X] By submitting this admission form, I agree that I've read and understood the statements above as well as the attached consent to treatment form and checklist.

NOTE: I ALSO UNDERSTAND THAT I NEED TO CONFIRM MY BED 10 DAYS PRIOR TO MY ADMISSION DATE. IF I FAIL TO CONFIRM MY BED IT WILL BE CANCELLED.

I ____ agree to the above ____________________
(Applicant Signature required) (Date)

If you prefer, you may print this form and fax it to us at (403) 328-5756

FOR OFFICE USE ONLY

Date Referral Received or Completed: ______________________________

PROGRAM OF INTEREST:
Alcohol & Drug Gambling

Program Booking Date: ______________________________

Wants to be On Stand-by List: Yes No

Went over checklist for admission Yes

Confirmation of booking received: Yes No

Notes: ______________________________

**** NOTE: ADMISSION CRITERIA - CLIENT MUST HAVE 5 FULL DAYS ABSTINENCE FROM ALCOHOL, DRUGS AND GAMBLING PRIOR TO ADMISSION. NO EXCEPTIONS. ALL CLIENTS WILL BE EXPECTED TO COMPLETE A URINE ANALYSIS TEST AND ALCOHOL SWAB UPON ARRIVAL FOR INTAKE.**

PART V TOBACCO (PRE-ASSESSMENT)

1) Please be advised South Country Treatment Centre at this time is not-tobacco free.

2) A designated area outside of the building is created for those clients who smoke. Visitors and employees are restricted from tobacco use while on Centre property.

3) E-cigarettes and smokeless tobacco products are prohibited.

4) If you have concerns related to this type of environment and feel at risk, we will provide direction and/or contact information on where to find a tobacco-free treatment program(s) which are suited towards accommodating your needs.

Do you currently use tobacco products? yes no

If no, you can proceed to the next section (Part VI) of this admission form.

If yes, complete the questions below. It is important to know that eliminating tobacco products along with substance abuse and problem gambling, produces better results concerning a healthy recovery from addiction.

---

1) How often do you consume tobacco products? daily weekly varies

2) Are you contemplating stopping use at this time? * yes no

3) Would you like to receive assistance concerning stopping? yes no

4) If nicotine replacement therapies (i.e. patches, gum) where made available to you while in treatment, would this influence your decision to stop? ** yes no

5) If you are not planning to quit smoking while in treatment, Would you like to have your counselor facilitate a referral for you to access counseling support beyond treatment? yes no

Note: The Centre provides education, counseling, and supportive materials related to tobacco and tobacco reduction. Should at any time during the course of your treatment your motivations change, simply address this with your counselor who will assist you.

* All clients attending the program (regardless of their motivation to not stop smoking),are still required to attend a one-hour “Smoking Cessation Program” during the course of their treatment.

** If nicotine replacement therapies are accessed by you, we recommend you consult with a physician first prior to using these products. Secondly, if yo these products and later resume your tobacco use while in discontinue providing these products.

CLIENT CHECKLIST FOR SOUTH COUNTRY TREATMENT CENTRE

(TO BE READ AND SIGNED BY APPLICANT)
FAX THE SIGNED CHECKLIST BACK TO SCTC AND PROVIDE THE CLIENT WITH A COPY

5 days prior to admission I will not take any of the following: over the counter medications (i.e. Gravol, Robaxicet, Tylenol muscle & body), disallowed prescription medications (i.e. Librium, Valium, Ativan, Restoril, Imovane, Tylenol #3, Flexeril), power or herbal drinks, vitamins, diet supplements or flavoured coffee creamers. **I will also not bring any of the above mentioned items on my admission day.**

I am aware that there is a 5 day minimum of sober/clean/gambling free time expected prior to admission.

I am aware that I will be expected to give a urine sample upon arrival for a urine analysis test. If I test positive for any substances I am aware I will not be admitted. I am aware I may also be randomly tested throughout my stay at SCTC.

I will confirm my bed 10 days before my admission date and will call the Intake Coordinator every week to check in. I am aware that failure to do so will result in my treatment date being bumped or taken off the list completely.

I have made arrangements for funding for my treatment.

I have provided all legal paperwork that is required.

I am aware I will not be allowed to attend medical appointments or court dates while I am at SCTC. I have rescheduled all medical and legal appointments until after I have completed the 28 day program.

I have enough medication (**must be blister packed at the pharmacy**) to last while I am in the 28 day program.

I will bring my own unscented and alcohol free personal toiletries. (No perfumes, body sprays or colognes as we are a scent free facility)

I have clean, appropriate clothing and footwear for the weather, running shoes, some type of sleep wear, underwear and socks.

I have enough cigarettes to last until the Monday evening after my admission.

I will bring towels/face cloths, fabric sheet softeners and a calling card for the payphones.

I have made arrangements for any personal monies I may need during treatment (I will be responsible for my money which can be locked in my locker – SCTC will provide the lock).

I will not bring in any electronics (i.e. e-cigarettes, vapes, televisions, cameras, computers, pagers, clocks, radios, DVD players, CD players, iPods, MP3 players, musical instruments, video games, DVD's, CD's, etc.). **NOTE cell phones will be locked up upon admission**

I will not bring in any offensive or pornographic magazines, weapons (i.e. pocketknives, blades etc.), clothing promoting any type of alcohol, drug or gambling, bicycles, skateboards, reports, projects or papers related to my work or profession.

I am aware that my baggage will be searched upon my arrival at SCTC.

I am aware I am responsible for my return transportation on my discharge date.

I, ______________________________, understand and will abide by the above Checklist for South Country Treatment Centre. I understand that providing incomplete and/or

inaccurate information may be cause for refusal of admission or if already in South Country Treatment Centre – termination from South Country Treatment Centre.

Client Signature: _______________________________ Date: ______________________

Referral Worker Signature: ________________________ Date: ______________________
(if applicable)

SOUTH COUNTRY TREATMENT CENTRE

Client Consent To Treatment

Welcome to South Country Treatment Centre! We hope your stay with us over these next four weeks is informative and helpful, and provides you with the necessary "tools" for your recovery.

The "Consent To Treatment" form is an agreement which allows us to provide you with a treatment service, and for you to understand those key elements of this service.

I, ____________________________ (print name) do hereby voluntarily consent to participate in the treatment program at South Country Treatment Centre.

I understand this treatment program encompasses the following areas:

a) Group therapy sessions,
b) Psycho-social educational presentations
c) Written assignments
d) Attending outside 12 Step Meetings
e) Recreational activities (including morning walks)
f) One-to-one counseling sessions

I understand South Country Treatment Centre is not a medical facility. Health and medical concerns and/or assessments are referred to outside programs and services. (i.e. hospitals, walk-in clinics).

I understand disclosures and observations made during the course of my treatment may be recorded and I will have a confidential record/file maintained by South Country Treatment Centre.

I understand statistical information involving name, gender, date of birth, and AHC Number may be disclosed to Alberta Health Services.

I have carefully read and understood all of the above information, I am fully aware of what I am signing and this information has been explained to me.

Client Signature: ______________________ Date: _____/______/_____
(D) (M) (Y)

Staff Signature: _________________________ Date: _____/______/_____
(D) (M) (Y)