Native Horizons Treatment Centre

130 New Credit Road
Hagersville, ON
N0A 1H0
T: 905-768-5144
Toll Free: 1-877-330-8467
F: 905-768-5564
E-mail: office@nhtc.ca

REFERRAL AND CLIENT INFORMATION

Native Horizons Treatment Centre is a fifteen (15) bed, co-ed five (5) week residential treatment program. This package will provide the information necessary to apply for our program. For facsimile purposes, please keep the application one-sided and only return pages four to fourteen (4 – 14), the Drug Use Screening Inventory (DUSI-R) and the Native Wellness Assessment (NWA) tools.

Enclosed are the following documents:

Adult Intake/Referral Form:

- All areas must be completed.
- Court documents must be attached.
- Client and referral signatures are required.

Medical Forms:

- An updated medication list is required.
- TB skin test and results are required (can be completed by a Registered Nurse, Nurse Practitioner and/or Physicians) every twelve (12) months.

Release of Information:

- Client must specify referral worker and/or any other person(s) authorized to receive information.
- Client and referral worker signatures are required.

Drug Use Screening Inventory Revised Questionnaire (DUSI-R):

- This assessment requires one answer only (yes or no) for each question.
- If the question does not apply to you, please answer no.

Native Wellness Assessment (NWA):

- This assessment requires one answer only for each question.

Personal Items Checklist:

- This document is for client information only.

Please read the following information:

Native Horizons requires and accepts referrals from the following sources **only**:

- Community-based frontline workers (NNADAP, Mental Health Workers, Counsellors, etc.).
- Indigenous/Non-Indigenous Service Agencies.

Our re-admission policy stipulates that:

- Priority will be given to the clients who have not attended residential treatment within the past six (6) months.
- Clients re-applying must establish proof of continuing care since discharged from any previous treatment program.
- Re-admission to Native Horizons cannot be guaranteed and will be assessed on an individual basis.

Criteria for Native Horizons to refer an applicant to another facility/agency includes:

- We are not a medically equipped facility; therefore, we currently do not accept clients on Methadone, Suboxone, Narcotics (including Tylenol-3), Ativan or any Anti-Psychotic medications.
- Applicants who have been diagnosed with Bi-Polar Disorders, Personality Disorders, FAS/FASD, brain injury or severe physically dependent persons.
- Clients being referred by medical professionals or from medical facilities (including withdrawal management).
- Clients that are pregnant.
- Clients currently incarcerated and/or have not been out of custody for a minimum of thirty (30) days.
- Only two (2) clients with legal involvement will be accepted per program cycle.
- Clients who have not maintained fourteen (14) days free of alcohol and/or drugs.
- Couples and relatives cannot be accepted into the same program cycle; one may be considered for the following program cycle.

The following is the application process into Native Horizons program cycle:

- Referral worker and client must complete four (4) pre-treatment sessions to determine if residential treatment is appropriate for the client (excluding filling out the application).
- Referral worker and client must complete Native Horizons intake application together.
- Incomplete applications will be held for thirty (30) days before being discarded.

1. Client application is received and entered into our Addiction Management Information System (AMIS).
2. Intake worker reviews and screens application to determine eligibility for the potential client.
3. A telephone interview is scheduled with the client and/or the referral worker.
4. Application is forwarded to the treatment team for decision of acceptance or alternative resources.
5. After treatment team's decision is made, a letter is sent stating approval or denial to the referral worker and/or client.

6. Referral worker and client continue to prepare for treatment and/or alternative resources.

Additional Information:

- Please bring identification documents on intake day (Health card, Status card, Social Insurance card).
- All medication must be in blister packs for five (5) weeks.
- Medication must be prescribed by a physician.
- Vitamins and/or any other supplements not prescribed by a physician, must be in unopened containers and may be approved.
- All medications (prescribed and non-prescribed) are secured and monitored by staff.
- Clients must bring sufficient supplies of personal items – toiletries, cigarettes, money, etc.
- Starting the fourth (4th) Sunday of the program client's privilege of television and telephone calls begin.
- Week four (4) Saturday and week five (5) Sunday clients earn weekend day passes from 12:00 p.m. – 10:00 p.m.
- Clients are allowed visitors starting on the fourth (4th) Sunday of the program from 1:00 p.m. – 4:00 p.m.
- Incoming client mail begins after 5:00 p.m. on the fourth (4th) Friday of treatment. Outgoing mail is sent on a weekly basis.
- All money and valuables of the client may be secured until privileges are granted.
- Transportation to and from Native Horizons for any reason is the sole responsibility of the client and/or the client's First Nation.
- Laundry machines and supplies are provided. If you require special or preferred supplies, please bring your own as Native Horizons cannot provide additional supplies.
- All food (and other) allergies must be documented in the application package with supporting medical documents. Native Horizons tries to accommodate food allergies as much as we can, however, this is not always possible. We will not cater to food preferences and dislikes.
- Native Horizons Treatment Centre is equipped and monitored by security cameras.

Native Horizons Treatment Centre is committed to the continued healing of our communities!

Native Horizons Treatment Centre

INCOMPLETE APPLICATIONS WILL DELAY THE INTAKE PROCESS

Form to be completed by Referral Agent **and** Client
If information is not applicable, indicate as **NA**, unknown as **UNK** and unavailable as **UNA**. Attach a separate sheet of paper if more space is needed.
PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED

ADULT INTAKE/REFERRAL APPLICATION

A. General Information			
Date Application Received by Community Worker:		Date Application Received by Treatment Centre:	
Surname:	First Name:		Preferred Pronouns:
Date of Birth:	Age:	Sex:	Provincial Health Card Number:
Full Mailing Address:			Telephone Number:
Personal E-mail Address:	Reside On or Off Reserve:		Social Insurance Number:
Status Native/Metis/Non-Status:	Status Number:		Band Name:
Education: (Incomplete/Completed High School, College, University)			Employment Status:
Emergency Contact Name:	Telephone Number:		Relationship to Emergency Contact:

Family/Relationships		
Marital Status: ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widowed		
Does the client have dependent children?	☐ Yes ☐ No	
If yes, do they have access to adequate childcare while client is in treatment?	☐ Yes ☐ No ☐ Not Applicable	
Are the children in care of Child Protection Services?	☐ Yes ☐ No ☐ Not Applicable	
Does the client have other dependents?	☐ Yes ☐ No	
Provide information on client's children or other dependents: (continued on next page if more space is needed)		
Name	**Age**	**Relationship**

Please list the client's family support system and their relationship to the client:

Please list the strengths of the client's familial support system:

Legal Status:	
Has the client been court ordered to attend treatment?	☐ Yes ☐ No
If yes, provide details (include copy of legal order):	
Is the client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temporary Absence Order ☐ Charges Pending ☐ Restorative Justice ☐ Probation ☐ Other
Has the client ever been charged with a criminal offence? If yes, please list charge(s) and date(s) of offence(s):	

Treatment History:	
Has the client participated in a non-residential/community-based substance abuse program?	☐ Yes ☐ No
Has the client participated in a non-residential/community based mental health program?	☐ Yes ☐ No
Has the client participated in a residential treatment program before?	☐ Yes ☐ No

If yes, please provide information on previous treatment experience: (continued on next page)

Year	Treatment Centre	Type of Addiction	Completed	Comments

			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Reason(s) for currently requesting treatment:

B. Withdrawal Symptoms

Has the client experienced any of the following symptoms while withdrawing from substances in the last six (6) months?

Symptom		Describe
Blackouts	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Hallucinations	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Nausea/Vomiting	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Seizures	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Shakes	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Delirium Tremens (DT's)	☐ Yes ☐ No ☐ Not Applicable	

Ever experienced DT's?	☐ Yes ☐ No	

C. Mental Health		
Provide the following information about the client's health status:		
Mental Illness		**Describe**
Has the client been diagnosed with a mental illness?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Is the client currently being treated for any mental health issues?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, is the client taking medication consistently and as prescribed?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Previous suicide attempts?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, when?		
Hospitalized for suicide attempts?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, when?		
Currently suicidal?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Name of Psychiatrist and/or Psychologist, telephone number and address (if applicable):	Name: Title:	Telephone: Address:

D. Process/Behavioural Addictions		
Has the client experienced problems with any of the following?		
Process/Behavioural Addictions		**Describe**
Gambling (slots, cards, bingo, etc.)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.):	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Sex (promiscuity, pornography, etc.):	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Internet/Texting:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Video Games:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

E. Other Issues/Needs	
Does the client have cultural and/or spiritual beliefs and practices we should be aware of? If yes, please describe:	☐ Yes ☐ No
Does the client have any literacy or learning needs or issues we should be aware of? If yes, please describe:	☐ Yes ☐ No
Are there any other significant issues we should be aware of? If yes, please describe:	☐ Yes ☐ No
Does the client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment?	☐ Yes ☐ No

Does the client understand there is an expectation they have been alcohol and drug free for at least fourteen (14) days prior to admission to residential treatment? They have been out of incarceration for a minimum of thirty (30) days prior to admission? (Client with less than the required days must notify the treatment centre prior to admission)	☐ Yes ☐ No
Please list your personal strengths:	

Client's Stage of Readiness: Please choose one of the following:

- ☐ Pre-contemplation – Not considering change; resistant to change.
- ☐ Contemplation – Unsure of whether to change, chronic indecision.
- ☐ Determination – Preparation; committed to changing behaviour within one month.
- ☐ Action – Begin changing behaviour.
- ☐ Maintenance – Behaviour change has persisted for six (6) months or more

Please identify all concerns/issues you're currently experiencing:

☐ Child Welfare Involvement	☐ Replacement of Identification	☐ Food Security
☐ Ontario Works Assistance	☐ Report-in to Authorities	☐ Job Security
☐ Disability Assistance	☐ Reliable/Safe Housing	☐ Re-entering the community
☐ Continuing Education	☐ Relocating	☐ Homelessness
☐ Dental Needs	☐ Sexual Health Concerns	☐ Adverse Effects of Medication
☐ Sleep-Wake Disorders	☐ Eating Disorders	☐ Other:
☐ Financial Crisis	☐ Family Court	

What areas might need to be addressed in treatment?

☐ Low Self-Esteem	☐ Physical Abuse	☐ Inability to Express Emotions
☐ Grief and Loss	☐ Sexual Abuse	☐ Depression
☐ Hatred of Self	☐ Verbal Abuse	☐ Anxiety
☐ Hatred of Others	☐ Emotional Abuse	☐ Sexual Identity
☐ Mistrust of Others	☐ Spiritual Abuse	☐ Criminal Activity
☐ Boundaries	☐ Foster Care/Adoption	☐ Gang Affiliation
☐ Rejection	☐ Residential/Boarding Schools	☐ Anger
☐ Abandonment	☐ Parenting Skills	☐ Mental Health
☐ Suicide	☐ Cultural Oppression	☐ Other:

F. Application Checklist	
Has transportation **to** Native Horizons Treatment Centre been arranged and confirmed?	☐ Yes ☐ No
Has transportation back home **from** Native Horizons Treatment Centre been arranged and confirmed?	☐ Yes ☐ No
Client has been notified and understands of the Non-Insured Health Benefits (NIHB) policy change, that whereby medical transportation benefits have been provided and the client self-terminates or Native Horizons Treatment Centre terminates the client anytime during the treatment process, the client will have to assume the costs of the next trip to access medically required health services and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada.	☐ Yes ☐ No

Client Authorization	
I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by Native Horizons Treatment Centre.	
Client Signature	**Date**
Referral Signature	**Date**

G. Referral Information				
First Name:		Surname:		
Agency:		Title/Position:		
Agency Address:		Telephone Number:		
Fax Number:		E-mail Address:		
Has the client completed four pre-treatment appointments? (Not including filling out application)				☐ Yes ☐ No
Please provide appointment dates: (YYYY/MM/DD)	Date 1:	Date 2:	Date 3:	Date 4:
Please provide session topics for each date:				
Will you continue to see the client once he/she has completed treatment? If not, why?				☐ Yes ☐ No

What other supports are available to the client in their community upon return from Native Horizons?

Name/Resource	**Description of Support**

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MEDICAL AUTHORIZATION

I hereby give authorization to the Physician signed below, for the release of all pertinent medical information related to my present medical condition, to Native Horizons Treatment Centre. I understand that by signing this form, Native Horizons Treatment Centre has the right to contact the Physician, if the need to consult arises. I also acknowledge that this is not an insured service and any cost incurred for the completion of this form is my sole responsibility. **Please note: A qualified medical practitioner is required to complete all areas of this form.**

Client Name:	Client D.O.B:
Health Card No:	Status (10 digit) or Social Insurance No:

Please indicate where the client has experienced any recent (within the past six (6) months) history of the following:

Medical Condition		Describe
Head/Body Lice	☐ Yes ☐ No ☐ Unknown	
Scabies	☐ Yes ☐ No ☐ Unknown	
Impetigo	☐ Yes ☐ No ☐ Unknown	
Rheumatic Fever	☐ Yes ☐ No ☐ Unknown	
Communicable Diseases	☐ Yes ☐ No ☐ Unknown	
Asthma	☐ Yes ☐ No ☐ Unknown	
Sexually Transmitted Diseases	☐ Yes ☐ No	

	☐ Unknown	
HIV/AIDS	☐ Yes ☐ No ☐ Unknown	
Hepatitis A/B/C	☐ Yes ☐ No ☐ Unknown	
Injectable Drug Use	☐ Yes ☐ No ☐ Unknown	
Cancer	☐ Yes ☐ No ☐ Unknown	
Pregnancy	☐ Yes ☐ No ☐ Unknown	
Diabetes	☐ Yes ☐ No ☐ Unknown	
Food/Other Allergy	☐ Yes ☐ No ☐ Unknown	
Psychiatric and/or Mental Health Involvement	☐ Yes ☐ No ☐ Unknown	
Withdrawal Symptoms (Please provide details of substance use)	☐ None ☐ Moderate ☐ Severe	
COVID:	☐ Yes ☐ No ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Unknown	
Note: **A T.B. Test is required by all clients to attend Native Horizons Treatment Centre**. If a Mantoux test results in a positive, a chest x-ray is mandatory. Please send to Native Horizons Treatment Centre when results are completed.		

Test Type:	Date:	Results:
T.B. Test		
Chest X-Ray		

Please provide details of all current medication(s) prescribed to the client. If more space is needed, please attach a separate sheet of paper to this form.

Medication Name:	Dosage:	Used For Treatment Of:	Initial Date Prescribed:	Prescribed By:

Note: Please refrain from discontinuing medications prior to treatment admission date. Ensure that the client has been stabilized on the correct dose before attending treatment. Also, please ensure the client brings enough prescribed medications **(blister packaged)** to last for five (5) weeks of Native Horizons program.

Medical Practitioner First Name:	**Last Name:**
Telephone Number:	**Full Mailing Address:**
Medical Practitioner Signature:	**Date:**
Client Signature:	**Date:**

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RELEASE OF INFORMATION

Release of Information			
Having read and understood this form, I hereby authorize Native Horizons Treatment Centre to Release/Request the following information To/From the Person/Agencies listed. In order for this release to be valid, one column must be **check marked and initialed by the client** for each of the following persons/agencies and area of disclosure:			
**Persons/Agencies ***Please specify your referral worker below*	**Yes**	**No**	**Initials**
1.			
2.			
3.			
4.			
5.			
Area of Disclosure	**Yes**	**No**	**Initials**
1. Discharge Summary			
2. Continuing Care Plan			
3. Progress Reports			
4. Treatment Plan			
5. Other – Specify:			
I understand that any other information will not be released to any other person without my written consent unless they have a court order or are concerned with my medical treatment in an emergency. I also understand that I can withdraw my consent to the release/request of information at any time and that in any event this form will be void ninety (90) days from the date of my signature.			
Client Signature		**Date**	
Referral Signature		**Date**	
When, in the opinion of the healthcare provider, the physical and/or mental condition of a client prevents him/her from having the ability to understand the subject matter in respect of which consent is requested and from being able to appreciate the consequences of giving or withholding consent, authorization for disclosure of the information may be given by the client's next of kin.			
Signature of authorized person to sign in lieu of client	**Print Name**		
Relationship to client	**Date**		

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PERSONAL ITEMS CHECKLIST

FOR CLIENT INFORMATION ONLY

All community members are expected to always wear appropriate clothing. **Appropriate attire does not include**:

☐ Short shorts	☐ Torn jeans	☐ Low-cut shirts
☐ Muscle shirts	☐ Halter tops	☐ Tube tops
☐ Clothing stamped with alcohol and/or drug symbols	☐ Clothing with violence or weapons	☐ Clothing with vulgar language
☐ Bikinis	☐ See-through clothing	

The first three (3) weeks of treatment are for the community members to focus on their healing, without distractions. Therefore, if any of the following items are brought into treatment, they will be locked-up and may be given back during scheduled passes, if granted. All other items not appropriate will be given back at the end of the program.

☐ Cell phones	☐ Junk food/Pop	☐ Journal books
☐ Computers	☐ IPod/IPad/Tablet/MP3	☐ CD's
☐ DVD's	☐ Radios	☐ Clocks
☐ Colouring books	☐ Novels/Books/Magazines	☐ School work
☐ Craft material	☐ Hair dye	☐ Knives/Weapons
☐ Pornographic material		

Appropriate Clothing Items (Seasonal):

☐ Underwear	☐ Socks	☐ Shirts
☐ Blouses	☐ Jeans	☐ Sweatpants
☐ Sweaters	☐ Running shoes	☐ Boots
☐ Bathrobe	☐ Slippers	☐ Pajamas
☐ Coat/Jacket	☐ Gloves	☐ Hats/Toques
☐ Snow pants	☐ Wind pants	☐ Sandals

Toiletries (All items must be alcohol free and non-aerosol):

☐ Toothpaste	☐ Shampoo and Conditioner	☐ Deodorant
☐ Razors	☐ Feminine products	☐ Shaving items
☐ Brush/Comb		

Sweat Attire:

☐ Skirt/Cotton night gown	☐ Shorts	☐ Large towel

Other Appropriate Items:

☐ Watch	☐ Limited amount of make-up	☐ Money
☐ Bank/Credit card	☐ Cultural items	☐ Limited musical instruments