Native Horizons Treatment Centre

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GRIEF AND LOSS PROGRAM APPLICATION

The client must complete all areas of the application
A referral worker is not required to apply

A. General Client Information:			
Date:		Date Application Received by Treatment Centre:	
Surname:	First Name:		Preferred Pronouns:
Date of Birth: (DD/MM/YYYY)	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:
Emergency Contact Name:	Emergency Contact Telephone Number:		Relationship to Emergency Contact:

B. Referral Information:	
First Name:	Surname:
Agency:	Title/Position:
Agency Address:	Email Address:
Telephone Number:	Fax Number:

C. Legal Status: (continued on the next page)

Is the client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temporary Absence Order ☐ Charges Pending ☐ Restorative Justice ☐ Probation ☐ Outstanding Warrants ☐ Other:
Does the client have upcoming court dates that may interfere with this program?	☐ Yes ☐ No
If yes, when are the court dates? (DD/MM/YYYY)	

D. 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

Please provide information on previous treatment experience:

Year	Treatment Centre/Program	Type of Addiction	Completed	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

E. Health

Provide the following information about the client's mental health status:

Mental Illness:		Describe
Has the client been diagnosed with a mental illness?	☐ Yes ☐ No	Please list diagnoses:
Is the client currently being medically treated for any mental health issues?	☐ Yes ☐ No ☐ Not Applicable	Please list medications and dosages:
If yes, is the client taking medication consistently and as prescribed?	☐ Yes ☐ No ☐ Not Applicable	

Previous suicide attempts?	☐ Yes ☐ No	
If yes, when?		
Hospitalized for suicide attempts?	☐ Yes ☐ No	
If yes, when?		
Currently suicidal?	☐ Yes ☐ No	
Medical Condition:		**Describe**
Food/Other Allergy	☐ Yes ☐ No	Please list:
Pregnancy	☐ Yes ☐ No	
Tuberculosis:	☐ Yes ☐ No	
Communicable Diseases	☐ Yes ☐ No	Please list:
Sexually Transmitted Diseases	☐ Yes ☐ No	Please list:
Hepatitis A/B/C	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Physical Limitations	☐ Yes ☐ No	Please list:
Acquired Brain Injury:	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

Does the client have upcoming medical or dental appointments that may interfere with this program?	☐ Yes ☐ No
If yes, when are the appointment dates and what is the reason for each appointment? (DD/MM/YYYY)	

F. Substance Use: Please indicate your substance use history (continued on the next page)

Substance	**Date Last Used**	**Amount Used**	**Describe**

Alcohol	☐ Yes ☐ No			What did you drink?
Marijuana	☐ Yes ☐ No			
Drugs	☐ Yes ☐ No			What did you use?

Please describe why you believe you use alcohol or drugs:

G. Types of Grief: Please indicate the types of losses you've experienced

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Partner
- ☐ Child
- ☐ Aunt
- ☐ Uncle
- ☐ Cousin
- ☐ Friend
- ☐ Elder
- ☐ Chief
- ☐ Community
- ☐ Relationship
- ☐ Home
- ☐ Pet
- ☐ Job
- ☐ Financial
- ☐ Divorce
- ☐ Health
- ☐ Identity
- ☐ Innocence
- ☐ Other:

H. Impacts of Grief: Please indicate how the losses have impacted your life in the following areas

Mentally:

Emotionally:

Physically:

Spiritually:

Relationships:

I. Grief Management: Please indicate how you manage/cope with grief

☐ Journaling	☐ Day Programs	☐ Support Groups
☐ Medication	☐ Exercise	☐ Counselling
☐ Self-help Books	☐ 12 Step Programs	☐ Cultural Practices
☐ Drugs	☐ Alcohol	☐ Other:
☐ Other:	☐ Other:	☐ Other:

J. Your Journey:

Please indicate what you would like to learn/work on in this program

K. Other:

Do you have additional comments or information we should be aware of?