



ACTION NORTH RECOVERY CENTRE

P.O. Box 872
High Level, AB T0H 1Z0

-ADMISSION FORM-

(Check off the one you are applying for :)

- 28 Day Treatment Program
- 14 Day Follow-up Program
- Long Term Program

Part 1 (Personal Information)

Name: _____
(Surname) (Given Name)

Address: _____
(Street) (City/Town) (Province/Territory) (Postal Code)

Phone No: _____ Age: _____ Date of Birth: _____

Sex: Male: Female: Marital Status: _____ S.I.N. _____

Length of Time Resident in Alberta: _____ Health Care No: _____

Occupation: _____ Employer: _____

Treaty No: _____ Band Name: _____

Next of Kin or Person to be notified in Case of Emergency:

Name: _____ Phone No: _____
(Surname) (Given Name)

Address: _____
(Street) (City/Town) (Province/Territory) (Postal Code)

Method of payment will be:

- Cash
- Certified Cheque
- Money Order
- HR & E
- Health Canada/Indian Affairs
- Other: PLEASE EXPLAIN _____

Social Services#: _____ Treaty Status#: _____ Band#: _____

Billing Address: _____
(Street) (City/Town) (Province/Territory) (Postal Code)

I agree to accept 28 Day/14 Day/Long Term Day Program, and release the enclosed information to Action North Recovery Centre in High Level, Alberta.

Applicant's Signature

Date:

B. Problem use of other Drugs:

Drug Name:

Number of Years Using:

_____	_____
_____	_____
_____	_____
_____	_____

C. Alcohol/Drug use pattern

Periodic/Binge:

1) Length of last binge _____ 2) Days between binges _____

Steady/Regular use:

1) Day of the week when heaviest _____

Reason: _____

D. Physical Drug/Drinking settings:

_____ Home	_____ Other Homes
_____ Work	_____ Public places e.g. Bars, etc...
_____ Driving	_____ Special gatherings e.g. Weddings, etc..
_____ Outdoors	

E. Social Drug/Drinking settings:

_____ Alone	_____ With only males
_____ With spouse	_____ With only females
_____ With friends	_____ With co-workers
_____ With relatives	_____ With anybody

F. Usual Reason for Stopping Drinking/Drugging:

G. Reasons for starting again.

H. Behaviour patterns when drinking/drugging: (e.g. Fighting, obnoxious, loud, outgoing, etc...)

I. a. Have you ever experienced mental health concerns: (for example, panic attacks, hallucinations/delusions, uncontrollable rage, mood swings, mental illness, etc.)? No Yes
If yes, what are the problems? _____

b. Please describe in detail how these problems affected you or others both in the past and currently:

c. If currently under the care of a doctor/psychiatrist/psychologist, please give name & phone number:

Name: _____ **Phone:** _____

J. Family: (e.g. Actual married situation, children, ages, location.)

K. Education/Employment: (e.g. Employed/unemployed, job history, length of employment/unemployment.)

L. Housing/Finances: (e.g. Is housing situation O.K., financial problems?)

M. Legal Involvement: (e.g. Next court appearance, fines, probation orders, previous types of charges.)

N. Leisure Activities: (e.g. Sports, crafts, arcade, etc...)

Please **READ CAREFULLY** the following before signing.

- a. I understand in order to be admitted to residential treatment I must remain alcohol and drug free for at least five days prior to my admission date, and be well enough to participate in the program. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be referred to an appropriate detoxification setting before treatment.
- b. I understand Action North Recovery Center is not responsible for my transportation or any other personal costs I may incur (e.g., approved medications) while I am in treatment. I will bring and give to staff all medications I am taking.
- c. I understand I cannot schedule any legal, dental, medical or personal business during the program.
- d. I understand and agree to accept and attend all components of the treatment program as prescribed by Action North Recovery Center, including all workshops, lectures, leisure and group counselling sessions.

Applicant Signature

Date

Office Worker Signature

Date

I give permission to Action North Recovery Center to disclose my name in order to obtain further information that is necessary to determine my suitability to residential treatment, confirm my method of Room and Board payable and/or to confirm that I will be reporting for residential treatment as scheduled.

Applicant Signature

Date

Office Worker Signature

Date

SECTION TWO: To be completed by the Referring person. Please print clearly.

If you are a self-referral, please check this box and skip this section.

Referring Person's Name: _____

Your Agency: _____

Professional or personal relationship to Applicant: _____

Business Address: _____

_____ Postal Code: _____

Phone Number: _____ Fax Number: _____

Type of Referral (Check the box which most applies)

- | | | |
|--|--|---|
| <input type="checkbox"/> AADAC | <input type="checkbox"/> Health/Medical –Doctor | <input type="checkbox"/> Business/Workplace, specifically |
| <input type="checkbox"/> Other Addictions Agency | <input type="checkbox"/> Health/Medical – other | <input type="checkbox"/> EAP |
| <input type="checkbox"/> Relative/Friend | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> Pastoral | <input type="checkbox"/> Justice Legal | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Other | <input type="checkbox"/> WCB/Disability Management | <input type="checkbox"/> Private Employer |

What is your assessment of the applicant's readiness and motivation for Residential Treatment?

Other than alcohol, drug or gambling, what issues does the applicant need to address while in the program.?

Referring person's Signature: _____

Date: _____