Native Addictions Council of Manitoba

160 Salter St Winnipeg, MB R2W4K1
Phone (204) 586-8395 Fax (204) 589-3921

Welcome Package

Date of application: ________/___________/___________ (M/D/Y)

Program Details: *(Check which program you are registering for)*

- ☐ Open Group/Evening Support
- ☐ Residential
- ☐ Outreach

Personal Information

Date of Birth: ______/_______/______ (M/D/Y)

Full Name: ____

Nickname or other name known by: ____

Gender: *(check which applies)*

Female _____ Male_______ LGBTQ +___________ Other_____________

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Common-Law
- ☐ Other__________________________

Address: ____ City: _______________________________

Province: _________________________ Postal Code: ____________________

- ☐ Homeless
- ☐ Couch Surfing
- ☐ Without a Home
- ☐ Shelter
- ☐ Transient
- ☐ Other: _________________________

Phone: ____________________ Email _________________________ Facebook ______________________

Manitoba Medical Card # _______________________ PHIN: (9digits)______________________________

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Status: *(check one)*

- ☐ Metis
- ☐ Inuit
- ☐ First Nation

First Nation Community: ____

Band Number ____

Language preferred: ___________________________________

Languages spoken: ____

Level of Education: ___________________________________

Next of Kin in Case of Emergency:

- Name: ____
- Address: ____
- Phone: ____
- Relationship to you: ____

Source of Income: *(check all that apply)*

- ☐ Employment and Income Assistance (Welfare)
- ☐ In process of applying for EIA
- ☐ Unemployment Insurance (EI)
- ☐ In process of applying for EI
- ☐ Employed
- ☐ Unemployed
- ☐ Stay at home parent/caregiver
- ☐ School
- ☐ Other _________________________________ _________________________________

Legal Status: *(check all that apply)*

- ☐ Parole/Probation
- ☐ Currently on Bail
- ☐ Court Ongoing
- ☐ No Involvement
- ☐ No Contact Order

If so, please provide name of complainant ______________________________

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Program Mandatory: (*circle one*) - Yes / No

Referral Information: *(please check one)*

- ☐ Self
- ☐ Centralized Intake
- ☐ Detox
- ☐ NNADAP
- ☐ CFS
- ☐ Courts/Lawyer
- ☐ Other ____________________

If this is **not** a self-referral, provide contact name, address, and phone number of referrals

Name: ____
Position ____
Address: ____
Phone: ____
Fax: ____

What brought you to the decision to get help with your addiction(s)? *(please all that apply)*

- ☐ C.F.S. Order
- ☐ Taking a break
- ☐ Physical Health
- ☐ Life out of control
- ☐ Family
- ☐ Probation Order

Mental Health

Have you experienced any of the following?

- ☐ Previous suicide attempts
  - o If yes when? ____
- ☐ Hospitalized for suicide attempts:
  - o If yes, when? ____

Do you currently experience suicidal thoughts?

Do you take medication for any mental health?

Are these medications listed on your medical form?

Do you currently have a mental health professional you talk to regularly?

Do you have anything you would like to add?____

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Substances used: *(check all that apply and frequency)*
(e.g. daily, 3x/week, bi-weekly, monthly, less than a month ago, binge, not in past year)

- ☐ Alcohol..Frequency: ______________________________
- ☐ Meth Amphetamines..........................Frequency: ______________________________
- ☐ Crack/Cocaine ....Frequency: ______________________________
- ☐ Prescription Pills ....Frequency: ______________________________
- ☐ Gambling..Frequency: ______________________________
- ☐ Shopping ....Frequency: ______________________________
- ☐ Internet...Frequency: ______________________________
- ☐ Sex ....Frequency: ______________________________
- ☐ Eating..Frequency: ______________________________
- ☐ Hallucinogens (Acid, PCP) ....Frequency: ______________________________
- ☐ Other ____

When was your last use? ____

What did you use? ____

Have you injected a substance in the last 30 days? YES or NO

What was that substance? ____

Treatment History

Date	Treatment Center	Type of Addiction	Completed Yes/No

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Consent to Share Treatment Information

Native Addictions Council of Manitoba (NACM) staff will not disclose information received in confidence without written permission of our participant

Your information will always be handled in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) and the Personal Health Information Act (PHIA)

The purpose of this consent is to obtain your permission regarding collecting and sharing information in the AMIS (addiction management information system) database. AMIS does three things:

- It collects aggregate information to allow us to make program improvement and treatment decisions for the community we serve
- If provides a more secure electronic method for us to transfer confidential health information about you to other centers that are or will be treating you and request your information
- It allows other centers to electronically disclose their confidential health information about you to us if we request your information for your healing with us

I ______________________________hereby authorize the NACM to release and obtain information relevant to my assessment and healing journey with other centers.

An NACM counsellor has gone through this information with me and I understand it

___________________________	________________________________
APPLICANT NAME (PLEASE PRINT)	DATE
___________________________	________________________________
APPLICANT SIGNATURE	COUNSELLOR SIGNATURE

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Drug Screening Tool Policy

NACM is a total abstinence center. Our goal is to help the participant heal and live a sober, healthy life and the healing begin with staying abstinent.

Our programs will require each individual participating in our programs, to remain abstinent through-out the 7 weeks.

NACM uses drug screening tools to baseline your substance use upon entering program and through-out your stay here.

I agree and understand this policy.

I ____________________________________ hereby consent to being drug screened as requested
Participant name: *(Print)* by NACM.

______________________________________ ____________________________________
Participant signature Date: month/day/year

____
Referral/Counsellor Name *(print)*

_____________________________________ ____________________________________
Referral/Counsellor signature Date: month/day/year

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Treatment Plan

Participant Name: ______________________________ Date: ___________________________

1. What core issues/trauma are currently outstanding that will prevent your healing?

____

____

2. What are your goals while in program?

____

____

3. Is this your first time in program? *(circle one)* .... YES / NO

4. If no, what is different this time?

____

____

5. Are you willing to actively participate in all sessions, meetings, and one on one counselling?
   YES / NO *(circle one)*

6. What behaviors will prevent you from pursuing your goals in the program? (e.g. shyness, language barrier, anger, fear, jealousy)

____

____

7. Are you willing to take responsibility for your recovery? *(circle one)*.................... YES / NO

8. How will you keep yourself motivated while participating in the program?

____

____

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9. What physical changes do you hope to address while in treatment?

____

____

(e.g. nutrition, exercise, sleeping patterns)

10. Additional comments:

____

____

____

____

____

Participant Name: *(print)* ____________________________________

Participant Signature: _______________________________________

Counsellor Name: *(print)* __________________________________

Counsellor Signature: _____________________________________

Date: ____

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Counselling Session

Participant Name: ___________________________ Date: ________________________________

Counsellor: ____

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Closing Summary

Participant Name: ____________________________ Date: ____________________________

Program Results:

- ☐ Completed
- ☐ Incomplete
  - o No show
  - o Incarcerated
  - o Illness
  - o Withdrew
  - o Discharged due to: _____________________________________

First date attended ____

Last date attended ____

Summary:

____
____
____
____
____
____

Referrals:

____
____
____
____

Closed by: ___________________________

Counsellor's Name *(print)*

____

Counsellor's Signature

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