

**SASKATCHEWAN NNADAP  
TREATMENT SERVICES  
APPLICATION FOR TREATMENT  
SERVICES**

(Version 2 / October 2002)

*This application is the first step required to prescreen applicants for adult treatment at any of the NNADAP facilities listed below. Additional information maybe required by individual centres before a decision on acceptance is made.*

**New Dawn Valley Centre**

Box 400  
Fort Qu' Appelle, Sask  
S0G-1S0  
Ph: (306) 332-5637  
Fax: (306) 332-4815  
Email: [ndvc@sasktel.net](mailto:ndvc@sasktel.net)

**Cree Nation Treatment Haven**

Box 340  
Canwood, Sask  
S0J-0K0  
Ph: (306) 468-2072  
Fax: (306) 468-2758  
Email: [cree.nations@sk.sympatico.ca](mailto:cree.nations@sk.sympatico.ca)

**Mistahey Musqua**

Box 404  
Loon Lake, Sask  
S0M-1V0  
Ph: (306) 837-2184  
Fax: (306) 837-4414  
Email:  
[mistahey.musqua@sk.sympatico.ca](mailto:mistahey.musqua@sk.sympatico.ca)

**Athabasca Outpatient Project**

Box 162  
Black Lake, Sask  
S0J-0H0  
Ph: (306) 284-2124  
Fax: (306) 284-2173  
Email:

**Clearwater River**

Box 5010  
Clearwater River, Sask  
S0M-3H0  
Ph: (306) 822-2033  
Fax: (306) 822-2750  
Email: [crdnt@sk.sympatico.ca](mailto:crdnt@sk.sympatico.ca)

**Ekweskeet**

Box 280  
Onion Lake, Sask  
S0M-2E0  
Ph: (306) 344-2094  
Fax: (306) 344-4805  
Email: [ekweskeet@sk.sympatico.ca](mailto:ekweskeet@sk.sympatico.ca)

**Sakwatamo Lodge**

Box 3917  
Melfort, Sask  
S0E-1A0  
Ph: (306) 864-3631  
Fax: (306) 864-2204  
Email: [sakwatamo@sk.sympatico.ca](mailto:sakwatamo@sk.sympatico.ca)

**Saulteaux Healing & Wellness  
Centre**

Box 868  
Kamsack, Sask  
S0A-1S0  
Ph: (306) 542-4110  
Fax: (306) 542-32  
Email:

*\*\* Email copies of this form are available for electronic transmission. Please return completed form to the centre you are applying to.*

## SASKATCHEWAN NNADAP TREATMENT SERVICES APPLICATION FOR TREATMENT SERVICES

*This application is the first step required to prescreen applicants for adult treatment at any of the NNADAP facilities listed below. Additional information may be required by individual centres before a decision on acceptance is made.*

Case Number (centre use ONLY): _____	Date of Application: _____
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First Name: _____	Last Name: _____
AKA (alias): _____	
SIN #: _____	Health Card #: _____
Age: _____	Date of Birth: _____
First Nation: _____	Gender: _____ Marital Status: _____
Band #: _____	Address: _____
Treaty #: _____	Prov: _____ Phone: _____

### **Substance Use/Social History**

#### **Substances Used:**

_____ Alcohol	_____ Inhalants	_____ Prescription Drugs _____ (type)
_____ Marijuana	_____ Heroin	_____ Morphine
_____ Crack Cocaine	_____ Talwin & Ritalin	_____ Other: _____
_____ Cocaine	_____ Ecstasy	

Which is the drug of choice? \_\_\_\_\_

What is the pattern of use? (please circle)      daily    binges    weekly    other

Which of the following have been negatively affected by the use:

_____ School Attendance	_____ Legal Situation
_____ Family Relationships	_____ Psychological Health
_____ Physical Health	_____ Other: (please explain)
_____ Employment	_____

Is there any history of drug use in the family of origin? If yes please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any history of gambling problems or any other process addiction? Yes/No Explain:

\_\_\_\_\_

Are you now or have ever been an IV drug user? Yes/No Type: \_\_\_\_\_

As of today when was your last use of any substance? \_\_\_\_\_

What type? \_\_\_\_\_ How much? \_\_\_\_\_

What is the longest period you have been able to stay free of substances: \_\_\_\_\_  
When? \_\_\_\_\_

If changing your life becomes uncomfortable for you, how prepared are you to continue treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List the reasons you feel you were able to remain clean that length of time: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Why are you seeking treatment now?

- \_\_\_\_\_ To get children back
- \_\_\_\_\_ As a requirement of my employer
- \_\_\_\_\_ Court ordered (see legal)
- \_\_\_\_\_ Other, please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you attended treatment previously? Yes/No If yes, where and when? (list all):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have custody of any minor children? Yes / No

What are the plans for your children while you seek treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Did you or any member of your family attend residential school? Yes / No

Please detail relationship (ie mother) and years attended if available. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you presently involved with any other agencies (ie social services) that may provide continued support to you when you complete treatment? Yes / No \_\_\_\_\_ (agency name)

May we involve these agencies in your case planning? Yes / No

Contact name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Legal History**

Have you ever been convicted of a crime? Yes /No

If yes, please list convictions and dates: \_\_\_\_\_

Were you under the influence of any substances at the time of the above crimes? Yes /No

If yes, please explain: \_\_\_\_\_

Do you have any current outstanding charges? Yes / No

If yes, what are you charged for? \_\_\_\_\_

When and where is your next court appearance? \_\_\_\_\_

What is your current legal status? Parole Probation Bail Temporary Absence N/A

*\*\* You may be required to submit a formal list of past convictions prior to individual centre acceptance*

**Medical History**

Do you have any medical history of seizures, allergies, heart conditions, or diabetes? Yes /No

Explain: \_\_\_\_\_

Have you ever undergone a mental Health Assessment? Yes / No

If yes, would you be willing to share a copy of the assessment with our centre? Yes / No

Who provided the assessment and when? \_\_\_\_\_

If female, are you currently pregnant? Yes / No Estimated Due Date: \_\_\_\_\_

If yes, please provide details as to length of pregnancy, prenatal caregiver, and any substance use that has taken place during the pregnancy? \_\_\_\_\_

Are there any other medical concerns we should be aware of? \_\_\_\_\_

**Referral Source Questions**

Referral Name: \_\_\_\_\_ Position \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

How long have you been involved with this client? \_\_\_\_\_

To this point, how have you been involved in the client's recovery? \_\_\_\_\_

Has the client attended any intervention activities in your community? Yes / No If yes, provide details and dates. \_\_\_\_\_

In your opinion, what are the most important areas this client needs to address during treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What services will you provide related to continuing care and treatment after care upon program completion?  
\_\_\_\_\_  
\_\_\_\_\_

In your opinion what is motivating this client to seek treatment at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any other services currently involved in trying to assist this client? \_\_\_\_\_  
\_\_\_\_\_

Are you aware of any factors in this clients life (medical conditions or legal charges) that may pose a threat to other clients in residential treatment? \_\_\_\_\_  
\_\_\_\_\_

Has this client been referred to and denied treatment at any other centre? Yes / No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any information or reasons to believe this client may have difficulties related to FAS or FAE? Yes/No. If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you completed a SASSI or other form of addictions assessment? Yes / No  
If yes, please include a copy with this application.

**Referral Agent Oath:**

*I certify that the information contained in this section is true to the best of my knowledge.*

Signature \_\_\_\_\_ Date: \_\_\_\_\_

*Please fax or mail back to the treatment centre to which you are making the referral. Add additional pages as required.*

