Pelican High Peak
Youth Healing Lodge
70 Wellington Street
Sioux Lookout, ON P8T 1E1

Ka-Na-Chi-Hih Specialized
Solvent Abuse Treatment Centre
1700 Dease Street
Thunder Bay, ON P7C 5H4

Wakenagun
Youth Healing Lodge
5310 Highway 101 West
Timmins, ON P4R 0B5

CENTRALIZED REFERRAL FORM

PLEASE NOTE: ALL SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL.
Incomplete forms will be returned and may delay the intake process.

PLEASE CHECK OFF WHICH HEALING LODGE YOU ARE APPLYING FOR:

RESET / CLEAR FORM

- ◯ **KA-NA-CHI-HIH (18-29 YEARS OLD)**
- ◯ **WAKENAGUN (12-17 YEARS OLD)**
- ◯ **PELICAN HIGH PEAK (12-17 YEARS OLD)**

PART 1 – APPLICATION

A. PERSONAL INFORMATION

FIRST NAME: _____ LAST NAME: _____ MIDDLE NAME: _____

AGE: _____ DATE OF BIRTH (mm/dd/yyyy): _____ GENDER: _____ SEX: _____

ADDRESS: _____ PROVINCE/TERRITORY: _____ POSTAL CODE: _____

MARITAL STATUS: _____ PHONE #: _____

EMAIL: _____

HEALTH CARD #: _____ VERSION CODE: _____ EXPIRY DATE: _____

BAND NAME: _____ STATUS CARD #: _____

◯ STATUS INDIAN ◯ INUIT ◯ MÉTIS ◯ NON-STATUS

LANGUAGE(S) SPOKEN: _____ LANGUAGE(S) UNDERSTOOD:_____

REASON FOR REFERRAL:

B. PRIMARY CAREGIVER / EMERGENCY CONTACT INFORMATION

PRIMARY CAREGIVER

FIRST NAME: _____ LAST NAME: _____ MIDDLE NAME: _____

RELATIONSHIP TO YOU: _____ ADDRESS: _____

PROVINCE/TERRITORY: _____ POSTAL CODE: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

FAX: _____ EMAIL: _____

EMERGENCY CONTACT *(IF DIFFERENT FROM PERSONS ABOVE)*

FIRST NAME: _____ LAST NAME: _____ MIDDLE NAME: _____

RELATIONSHIP TO YOU: _____ ADDRESS: _____

PROVINCE/TERRITORY: _____ POSTAL CODE: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

FAX: _____ EMAIL: _____

C. REFERRAL INFORMATION

REFERRAL SOURCE: _____

FULL NAME: _____ RELATIONSHIP TO YOU: _____

WORK PHONE: _____ CELL PHONE: _____

FAX: _____ EMAIL: _____

IF WE CANNOT REACH YOU, IS THERE SOMEWHERE WE HAVE CONSENT TO LEAVE A MESSAGE FOR YOU?

_____

D. LEGAL INFORMATION

DO YOU HAVE ANY CURRENT ISSUES WITH THE LAW? ◯ YES ◯ NO

IF YES, PLEASE LIST ALL LEGAL CHARGE(S) / OFFENCE(S), INCLUDING ANY THAT ARE PENDING: _____

_____

_____

PLEASE CHECK OFF ALL THAT APPLY:

☐ CRIMINAL COURT ☐ FAMILY COURT ☐ DRUG COURT TREATMENT ☐ PROBATION

☐ CHARGES PENDING ☐ COURT REFERRAL ☐ COURT ORDER ☐ RESTORATIVE JUSTICE

☐ NO INVOLVEMENT

DO YOU CURRENTLY HAVE A PROBATION OFFICER? ◯ YES ◯ NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF PROBATION OFFICER: _____

PHONE #: _____ FAX #: _____

EMAIL: _____

PROBATION ORDER – FROM: _____ TO: _____

CONDITIONS: _____

_____

_____

DO YOU CURRENTLY HAVE A LAWYER? ◯ YES ◯ NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF LAWYER: _____

PHONE #: _____ FAX #: _____

EMAIL: _____

ARE YOU REQUIRED TO ATTEND COURT, IF YES, PLEASE PROVIDE DATE, TIME, AND A COPY OF THE ORDER:

_____

WERE ANY MIND-ALTERING SUBSTANCES INVOLVED DURING YOUR LEGAL PROBLEMS? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

_____

HAVE YOU EVER BEEN INVOLVED OR HAD ANY CURRENT GANG INVOLVEMENT? ◯ YES ◯ NO ◯ UNKNOWN

- **ALL INFORMATION PERTAINING TO CURRENT LEGAL MATTERS AND PROBATION ORDERS ARE REQUIRED TO BE FORWARDED WITH THE REFERRAL PACKAGE.**
- **NO REFERRAL WILL BE CONSIDERED UNTIL ALL DOCUMENTS ARE OBTAINED.**
- **CRITICAL INFORMATION THAT IS WITHHELD, FALSE, MISLEADING, OR FABRICATED MAY RESULT IN DISCHARGE, ESPECIALLY IN THE EVENT WHERE THE SAFETY OF OTHERS IS AT RISK.**

E. FAMILY HISTORY

DO YOU HAVE ANY DEPENDENT CHILDREN? ◯ YES ◯ NO

IF YES, WILL THEY HAVE ACCESS TO ADEQUATE CHILDCARE WHILE YOU ARE IN TREATMENT? ◯ YES ◯ NO

ARE THE CHILDREN IN CARE? ◯ YES ◯ NO

DO YOU HAVE OTHER DEPENDENTS? ◯ YES ◯ NO

WHAT IS YOUR CURRENT LIVING SITUATION? (*CHECK OFF ALL THAT APPLY)*:

- ☐ ON-RESERVE
- ☐ OFF-RESERVE
- ☐ URBAN
- ☐ RURAL
- ☐ IMMEDIATE FAMILY
- ☐ EXTENDED FAMILY
- ☐ LIVES ALONE
- ☐ HOMELESS
- ☐ GROUP HOME
- ☐ SHELTER
- ☐ FOSTER CARE
- ☐ COMMON LAW
- ☐ FRIEND

HAS THERE OR IS THERE CURRENTLY ANY CHILD WELFARE INVOLVEMENT? ◯ YES ◯ NO ◯ UNKNOWN

HAS ANYONE IN YOUR FAMILY OR COMMUNITY RECEIVED TREATMENT FOR SUBSTANCE USE? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

F. EDUCATION

ARE YOU CURRENTLY ATTENDING SCHOOL? ◯ YES ◯ NO

HIGHEST GRADE COMPLETED: _____

NAME OF LAST SCHOOL ATTENDED: _____

LAST YEAR ATTENDING THIS SCHOOL: _____

SCHOOL PHONE NUMBER AND/OR CONTACT INFORMATION: _____

DO YOU HAVE ANY SPECIAL NEEDS, LEARNING DISABILITIES, OR BEHAVIOURAL PROBLEMS THAT WE NEED TO BE AWARE OF? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

G. MEDICAL HISTORY

DO YOU HAVE ANY MEDICAL CONDITIONS? ◯ YES ◯ NO

IF YES, PLEASE IDENTIFY: _____

FAMILY DOCTOR'S NAME & PHONE NUMBER (if applicable): _____

PLEASE PROVIDE THE DATES OF YOUR LAST APPOINTMENTS FOR EACH OF THE FOLLOWING (approximately):

MEDICAL: _____

DENTAL: _____

OPTICAL: _____

DO YOU HAVE ANY ALLERGIES? ◯ YES ◯ NO

IF YES, PLEASE LIST ANY ALLERGIES AND THE REACTION TO THE ALLERGY:

_____

_____

PLEASE LIST ANY MEDICAL NEEDS WHILE ATTENDING PROGRAM:

_____

_____

ARE YOU CURRENTLY ON ANY MEDICATION? ◯ YES ◯ NO

Please ensure the Medical Assessment (PART 2) is completed by a Health Professional and attached to this application form.

H. SUBSTANCE USE HISTORY

AT WHAT AGE DID YOU START DRINKING ALCOHOL? _____ ☐ NOT APPLICABLE

AT WHAT AGE DID YOU START TAKING OTHER DRUGS? _____ ☐ NOT APPLICABLE

AT WHAT AGE DID YOU START USING SOLVENTS? _____ ☐ NOT APPLICABLE

HAVE YOU EVER GOTTEN INTO ANY PHYSICAL FIGHTS WHILE USING? ◯ YES ◯ NO

HAVE YOU EVER CAUSED SERIOUS INJURY TO SELF OR OTHERS WHILE USING? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN: _____

DO YOU REQUIRE A WITHDRAWAL MANAGEMENT PLAN BEFORE YOU ATTEND THE PROGRAM?

_____

HAVE YOU BEEN IN PREVIOUS TREATMENT FOR YOUR USE OF SUBSTANCES? ◯ YES ◯ NO

IF YES, PLEASE INDICATE WHERE, WHEN, HOW LONG YOU STAYED IN THE PROGRAM, AND THE REASON FOR DISCHARGE: _____

_____

HAVE YOU PARTICIPATED IN A NON-RESIDENTIAL / COMMUNITY BASED SUBSTANCE USE AND/OR MENTAL HEALTH PROGRAM? ◯ YES ◯ NO

IF YES, PLEASE LIST THE TYPES OF PROGRAM(S): _____

_____

I. PSYCHOLOGICAL FUNCTIONING

HAVE YOU EVER SPOKEN OR WRITTEN ABOUT KILLING YOURSELF? ◯ YES ◯ NO

HAVE YOU EVER ATTEMPTED TO KILL YOURSELF? ◯ YES ◯ NO

IF YES, HOW MANY TIMES AND HOW LONG AGO? _____

HOW DID YOU ATTEMPT TO KILL YOURSELF? _____

HAVE YOU EVER TAKEN PART IN SELF-HARMING BEHAVIOURS? IF YES, PLEASE EXPLAIN:

_____

DO YOU HAVE DIFFICULTLY WITH ANGER? IF YES, PLEASE EXPLAIN: _____

_____

DO YOU REQUIRE BEHAVIOURAL MANAGEMENT? IF YES, PLEASE EXPLAIN: _____

_____

HAVE YOU EVER DEMONSTRATED CRUELTY TO ANIMALS? IF YES, PLEASE EXPLAIN: _____

_____

DO YOU HAVE A HISTORY OF AGGRESSION TOWARDS OTHERS? IF YES, PLEASE EXPLAIN: _____

_____

DO YOU HAVE A HISTORY OF FIRE SETTING? IF YES, PLEASE EXPLAIN: _____

_____

DO YOU HAVE A HISTORY OF DESTROYING PROPERTY? IF YES, PLEASE EXPLAIN: _____

_____

IS THERE ANY KNOWN HISTORY OF SEXUAL ABUSE? ◯ YES ◯ NO ◯ UNKNOWN

IS THERE ANY KNOWN HISTORY OF PHYSICAL ABUSE? ◯ YES ◯ NO ◯ UNKNOWN

IS THERE ANY KNOWN HISTORY OF EMOTIONAL ABUSE? ◯ YES ◯ NO ◯ UNKNOWN

IS THERE ANY HISTORY OF FAMILY VIOLENCE THAT YOU MAY HAVE BEEN WITNESS TO?

◯ YES ◯ NO ◯ UNKNOWN

HAVE YOU EVER HAD ANY PSYCHOLOGICAL TESTING OR COUNSELLING? ◯ YES ◯ NO

IF YES, FOR WHAT PURPOSE? _____

_____

Please attach any psychological / mental health assessment(s) conducted to-date (i.e., psycho-educational, SASSI, MAST, DAST, etc.).

PLEASE INDICATE WHETHER YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS OR SPECIFY IF ANY OTHER DIAGNOSES:

DISORDER	DIAGNOSED
FETAL ALCOHOL SPECTRUM DISORDER (FASD)	☐
OPPOSITIONAL DEFIANT DISORDER (ODD)	☐
CONDUCT DISORDER (CD)	☐
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)	☐
ATTENTION DEFICIT DISORDER (ADD)	☐
OTHER:	

WHEN IN A SOBER STATE…

HAVE YOU COMMUNICATED WITH SPIRITS NO ONE ELSE CAN SEE OR HEAR?

◯ NONE OF THE TIME ◯ SOME OF THE TIME

◯ MOST OF THE TIME ◯ ALL OF THE TIME

ARE THESE ENCOUNTERS POSITIVE OR NEGATIVE EXPERIENCES FOR YOU?

◯ POSITIVE ◯ NEGATIVE ◯ INDIFFERENT

ARE THERE TIMES WHEN PEOPLE ARE UNABLE TO COMMUNICATE WITH YOU?

◯ NONE OF THE TIME ◯ SOME OF THE TIME

◯ MOST OF THE TIME ◯ ALL OF THE TIME

PLEASE EXPLAIN: _____

J. OUTSIDE RESOURCES

ARE THERE ANY OTHER AGENCIES IN YOUR CIRCLE OF CARE? ◯ YES ◯ NO

IF YES, WHICH AGENCIES AND WHAT SERVICES DO THEY PROVIDE? (i.e., NNADAP, CHR, CFS):

NAME OF AGENCY / RESOURCE PERSON	DESCRIPTION OF SUPPORT	CONTACT INFORMATION

K. CLOTHING INFORMATION

THIS INFORMATION IS FOR STAFF TO ENSURE YOU HAVE THE PROPER APPAREL FOR LAND-BASED ACTIVITIES AND TO ASSIST WITH REPLACEMENT IF SOMETHING HAS BEEN DAMAGED DURING YOUR STAY.

PLEASE PROVIDE US WITH YOUR CLOTHING SIZES BELOW:

SHIRT SIZE: _____ PANT SIZE: _____ SHOE SIZE: _____

BRA SIZE (if applicable): _____ UNDERWEAR SIZE: _____

Please submit your completed referral form to the Continuous Care Facilitator, Samantha Birnie at the following:

- **Email:** sbirnie@kanachihih.ca
  OR
- ***Fax:*** +18077899803

SUBMIT FORM

OR simply press this green 'Submit Form' button to submit your completed referral form pre-attached to an email.