



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



**Ka-Na-Chi-Hih  
Healing Lodge**  
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:**

**KA-NA-CHI-HIH (18-29 YEARS OLD)**

**WAKENAGUN (12-17 YEARS OLD)**

**PELICAN HIGH PEAK (FAMILY)**

### 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  | IMMEDIATE FAMILY | GROUP HOME  |
| OFF-RESERVE | EXTENDED FAMILY  | SHELTER     |
| URBAN       | LIVES ALONE      | FOSTER CARE |
| RURAL       | HOMELESS         | 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
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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 intake general email address at the following:*

- Email: intake@kanachihih.ca  
OR
- Fax: +1807-789-9803

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