HEALING JOURNEY REFERRAL

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED.
INCOMPLETE REFERRAL WILL NOT BE PROCESSED UNTIL FULLY COMPLETED.

General Information	
Relative Last Name:	Relative First Name:
Relative Full Address: **Please include Postal Code**	Relative Gender: F ☐ M ☐ Other: Relationship Status: Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widow/Widower ☐ Date/Year of Separation/Divorce/Widow/Widower:
Date of Birth: _____/_____/_____ Age: (dd) (mm) (year) Place of Birth:	Mother's Maiden Name:
Telephone Number: **May Benbowopka personnel contact you at the above telephone number:** Yes ☐ No ☐	Health Card Number: Expiry Date:
First Nation: Residing on First Nation: Yes ☐ No ☐ Duration?	Status Number:
Anishnabie Name:	
Relative Emergency Contact: Relationship to Emergency Contact:	Telephone Number: Cellular Number:
Family Physician:	Telephone Number:

Legal Status
Criminal Court System:
Pending Charges: Yes ☐ No ☐ List Charge(s): _____ _____ Probation: Yes ☐ No ☐ **Provide a copy of Probation Order** Scheduled Court Appearance: Date: _____

Revised June 2022

Mental Health and Addictions

Have you ever been diagnosed with a mental health illness/disorder? Yes ☐ No ☐

If yes, please note the mental health illness/disorder: _____ _____ (Date or Year)

Have you ever been hospitalized for your mental health illness/disorder? Yes ☐ No ☐ _____ (Date or Year)

Have you ever experienced suicidal ideations or attempted suicide? Yes ☐ No ☐

If yes, please note when:

Please describe personal difficulties you are experiencing for which you now seek knowledge, understanding, and coping skills, all of which will assist you on your healing journey:

Are you willing to attend Benbowopka Treatment Centre with a member of your own First Nation?
Yes ☐ No ☐

Please complete all sections

Substance	Age First Used	Frequency of Use	Amounts Used	Date of Last Use

MEDICAL RELEASE INFORMATION

CLIENTS REPONSIBILITIES: Please have all information completed by a Physician/Nurse Practitioner and return the completed form to Benbowopka Treatment Centre. Clients will not receive a treatment date confirmation without a completed Medical. **PLEASE NOTE: Benbowopka Treatment Centre will not be responsible for any cost with having the Medical Release Information completed. Thank you.**

Physician/Nurse Practitioner: Please Print	**Telephone Number:**
Client Surname:	**First Name:**
Date of Birth:	**Gender: M ❒ F ❒**
Telephone Number:	**Marital Status:**
Health Card Number:	
Client Address:	

Received COVID 19 Vaccine: Y ❒ N ❒ If yes, which vaccine? _____

Does this patient have any type of respiratory illness or disease that may prevent the use of COVID 19 masks? ❒ Y ❒ N

If yes, please describe:

_____

_____

Received Influenza Vaccine: Y ❒ N ❒ Received Pneumococcal Vaccine: Y ❒ N ❒

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Physical Health and Condition:

Please Note Any Future Medical Treatments Client May Require:

Does the client have a disability or mobility condition? Y ❒ N ❒ **If yes, please describe:** _____ _____

List Allergies: **Is an EpiPen Required: Y ❒ N ❒**	**Special Diet Required? Y ❒ N ❒** **Type:**

Psychological Condition: (History and Treatment)

PRESCRIBED MEDICATION
(Please use following page if necessary)

Medication and Dosage **PLEASE HAVE MEDICATION BLISTER PACKED**	Start and End Date of Medication	Psychoactive Effect (Yes/No)	Corresponding Diagnosis

Physician/Nurse Practitioner Signature:	**Date:**

Patient Consents to Sharing Personal Health Information with Benbowopka Treatment Centre.

_____ _____

Patient Signature **Date**

PRESCRIBED MEDICATION

Medication and Dosage **PLEASE HAVE MEDICATION BLISTER PACKED**	Start and End Date of Medication	Psychoactive Effect (Yes/No)	Corresponding Diagnosis

CIRCLE OF CARE: CONSENT TO THE RELEASE OF INFORMATION AND PLANNING FOR AFTERCARE SERVICES FORM

I, _____, give permission for the mutual exchange of information between the Benbowopka Treatment Centre and:

☐ Psychiatrist:	☐ Physician:
☐ Hospital/Health Staff (Specify):	
☐ Probation:	☐ Lawyer:
☐ NNADAP/Referral Worker:	
☐ Medical Transportation Services:	
☐ Other Treatment Centers/Withdrawal Management Services:	
☐ Family/Significant Other (Specify):	
☐ Other (Specify):	

In respect of _____ _____
(Print Name) *(Date of Birth)*

as it relates to the provision of care/service while at the Benbowopka Treatment Centre and planning for discharge/aftercare services for the individual named herein. This consent shall remain in effect from this date until the purpose for which the information was disclosed has been achieved and/or I am no longer involved in this service. It is understood that I can revoke this agreement at any time either verbally or in writing. I have read, understand, and agree to the terms and conditions outlined on the reverse side of this release.

_____ _____

(Signature) *(Witness/Staff Signature)*

Dated this _____ day of _____, 20_____.

Consent Withdrawn Date: _____, 20_____.

_____ _____

(Signature) *(Witness/Staff Signature)*

CIRCLE OF CARE: TERMS AND CONDITIONS FOR THE RELEASE OF INFORMATION AND PLANNING FOR AFTERCARE SERVICES

1. The Benbowopka Treatment Centre provides service through a team approach. From time to time this means client specific information must be shared with fellow employees of the Benbowopka Treatment Centre for case management and supervision and with other significant supports involved in the care and/or treatment of the client.

2. Confidentiality shall be maintained by employees of the Benbowopka Treatment Centre except where there is imminent risk of harm to self or others or when subpoenaed by the court.

3. All other release/review of client information by employees of the Benbowopka Treatment Centre shall only be carried out with the expressed consent of the individual as outlined in the Circle of Care: Consent to Release of Information and Planning for Aftercare Services Form signed by the client.

CONSENT FOR DISCLOSURE OF ADDICTIONS MANAGEMENT INFORMATION SYSTEM DATABASE (AMIS)

AMIS is a National Native Alcohol and Drug Abuse Program (NNADAP) and Youth Substance Abuse Program (YSAP). Treatment Centers have used a national case management database since April 2014. The AMIS database collects evidence that can be used to inform client care, demonstrated the strengths of NNADAP/YSAP and support research initiatives over time. AMIS enables Treatment Centers to view and analyze client data quickly and complete reporting more efficiently. In addition, the information enables Treatment Centers to better understand and demonstrate a particular client's needs.

I, _____, _____
(PRINT CLIENT FULL NAME) (DATE OF BIRTH)

hereby authorize and consent to the release of the **AMIS Database/Record** pertaining to myself, which may be held by any NNADAP Treatment Centre in Ontario or any province within Canada **to be released to Benbowopka Treatment Centre for the purpose of continuing care.**

Relative Signature: _____ Date: _____

Witness Signature: _____