

NGWAAGAN GAMIG RECOVERY CENTRE INC.  
(Rainbow Lodge)

## 2012 TREATMENT REFERRAL PACKAGE

- Program Information
  - 2012 Treatment Cycle Dates
  - Referral Forms
- 

### ATTENTION: REFERRAL AGENCY / APPLICANT

**NEW** at Ngwaagan Gamig: **the treatment program has been renewed; we utilize a more culturally-based, cognitive-behavioral approach for addictions treatment.**

Please find attached our revised **2012** client referral package for the four-week Alcohol and Drug Treatment Program at Ngwaagan Gamig Recovery Centre Inc. (Rainbow Lodge). Please begin utilizing this package for referrals. Your cooperation is appreciated.

This package contains information on the referral process, program information, application form, Pre-Admission Medical Form, admittance procedures, and upcoming cycle dates. Please make copies of this Treatment Referral Package for future use. You may fax the completed Treatment Referral Forms to (705) 859-2325 or mail to us.

**Please ensure all areas of the referral forms are completed in full.** Missing information will delay the process. We require **1)** the Collaborative Treatment Referral Form, **2)** the Pre-Admission Medication Form (both included). In, addition **3)** the A.D.A.T., Admission Discharge Assessment Tools (not included), to be submitted before the application is screened for appropriateness for our treatment program.

Clients are required to provide one (1) piece of picture identification before proceeding to Ngwaagan Gamig Recovery Centre; this identification will be requested by our drivers at the pick-up location or by staff upon arrival at the centre.

Thank you for considering Ngwaagan Gamig. If you have further inquiries regarding our intake procedure, please do not hesitate to call.

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*(Revised: Dec. 9, 2011)*

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P.O. Box 81,  
Wikwemikong, Ontario  
Tel: 1.705.859.2324  
Toll Free: 1.877.649.2242  
www.ngwaagan.ca

56 Pitawanakwat Street  
POP 2J0  
Fax: 1.705.859.2325  
1.877.ngwaagan  
General email: [rainbowlodge@amtelecom.net](mailto:rainbowlodge@amtelecom.net)

# PROGRAM INFORMATION

## REFERRAL PROCESS FOR TREATMENT

Referrals will be accepted from the following sources:

- self referrals
- community-based counsellors, CHR's, NNADAP
- social service workers
- Health-related agencies

The treatment program is intended for males and females, 18 years of age and older, determined to become abstinent from their substance use/abuse. Ngwaagan Gamig Recovery Centre Inc. will accept for treatment, First Nations people who meet the referral process from any Canadian geographical area.

## INTAKE PROCEDURES

1. Completion of the Collaborative Treatment Referral Form with Pre-Admission Medical Form
2. Standardized Assessment Tools to be submitted – (Admission, Discharge, Assessment Tools)
3. A telephone interview with the referral worker and/or client.
4. Screening of applications will be completed prior to approval. Incomplete applications will delay the process of screening.
5. Clients appropriate for our program will be put on a **WAIT LIST** until a bed becomes available. The client is expected to continue preparing for treatment by engaging in pretreatment services.
6. **Once a bed is available, an ACCEPTANCE LETTER with an ADMISSION DATE is sent. Admission to our centre is approved only with an Acceptance Letter.**
7. One week prior to admission, we will conduct a telephone interview with the client and receive an update on Pre-treatment services and/or client readiness.
8. Travel arrangements to and from the centre, the responsibility of the referral worker or client, are to be confirmed with our Intake office.
9. Any no shows on Admission Date will be considered cancellation, and beds will be filled with those on the wait list.

## PRE-TREATMENT CRITERIA

The referring agency representative is expected to prepare clients for treatment by making the client aware of the following:

- To review the treatment process with client, to familiarize client with alcohol/drug treatment programs, in the areas of house policies, resident's rights/responsibilities, and client expectations.
- Client is willing to attend to any pre-treatment activities
- Clients must be detoxified from alcohol and free with withdrawal symptoms at least one month
- Determined to live a healthier way of life.

- Clients must demonstrate willingness and be able to participate in treatment.
- All clients must be willing to abide by Ngwaagan Gamig Recovery Centre Inc.'s policies and procedures.
- Personal/Business matters which include finances, medical appointments, child care, family, personal relationships and legal issues must be taken care of prior to admission so as not to interfere with treatment.
- It is recommended that couples not be referred to the same four-week program.

## **ADMISSION PROCEDURES FOR TREATMENT**

- Monday is the usual travel day for admission day into our four-week treatment program.
- Time of arrival must be forwarded to intake office prior to admission. Any delays/cancellations must be reported as soon as possible by the worker or client. If we do not receive information of delays, this may result in loss of bed space.
- If a client changes his/her mind regarding admission, please telephone us as soon as possible.
- If a client appears on admission day **without having received the ACCEPTANCE LETTER**, this client **will not** be admitted into the treatment program nor facility. The client will be requested to return home to contact their referral source.
- If a client cancels his admission, his/her application will not be kept active, they will need to reapply.

## **STANDBY LIST**

- Once the beds have been filled, we continue with the "WAIT List". As cancellations occur, we will fill the bed spaces with applicants who are treatment ready.
- The referral agency will be contacted if a bed becomes available to determine if the their client is ready for treatment and able to attend. The client will need to arrive at our facility as soon as possible.

## **NO SHOW**

- On Tuesday, the following day of admission, we will telephone and advise the referral source if their client did not arrive for admission.
- If a client calls to cancel, we will ask client to contact their referral source to advise of same.

## **RE-ADMISSION**

- Requests for re-admission into our treatment program will be dealt with on an individual basis.
- Any referring agency requesting re-admission of a former client must be able to provide reasons why re-admission is likely to be helpful.

**NGWAAGAN GAMIG RECOVERY CENTRE INC.  
2012  
TREATMENT CYCLE DATES**

<b>CYCLE</b>	<b>Admission Day</b>	<b>Completion Day</b>	<b>Program Duration</b>
1	Professional Development	No Treatment Program	Professional Development
2	February 6,2012	March 2, 2012	4 weeks
3	March 12, 2012	April 5, 2012 (thurs)	4 weeks
4	April 16, 2012	May 11, 2012	4 weeks
5	May 22, 2012 (tues)	June 15, 2012	4 weeks
6	June 25 , 2012	July 20, 2012	4 weeks
7	August 13, 2012	September 7, 2012	4 weeks
8	September 17, 2012	October 12, 2012	4 weeks
9	October 22, 2012	November 16, 2012	4 weeks
10	November 26, 2012	December 20, 2012(thurs)	4 weeks

# COLLABORATIVE TREATMENT REFERRAL FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender :  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Health Card #: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address of Emergency Contact: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Contact Telephone #: \_\_\_\_\_

**ABORIGINAL ANCESTRY:**  YES  NO  Status  Non-Status  Metis  Inuit

Name of Band: \_\_\_\_\_ 10 Digit Band #: \_\_\_\_\_

**MARITAL STATUS:**  Single  Married  Common-Law  Divorced

Separated: Date Separated: \_\_\_\_\_

Widow: Date Widowed: \_\_\_\_\_

**LIVING ARRANGEMENTS:**  With Immediate Family  With Parents  Alone

With Extended Family  With Children  With Friends

Other: (Shelter, Detox, Transition House, Homeless, Recovery Home) \_\_\_\_\_

Are the people the client is living with using alcohol and/or drugs?  Yes  No

Is the client expected to return to this home/residence?  Yes  No

If no, identify new living arrangements \_\_\_\_\_

## **CLIENT'S CURRENT SITUATION:**

Does the client have outstanding charges:  Yes  No

Indicate upcoming Court Date, if applicable: \_\_\_\_\_

Family Court  Criminal Court

Is the client currently on:  Bail  Parole  Probation  Other: \_\_\_\_\_

**If so, a copy of the order/conditions is required.**

Is Treatment a Condition?  Yes  No  N/A Of what? \_\_\_\_\_



## PRIOR ALCOHOL AND DRUG ABUSE TREATMENT

**IN-PATIENT** (List most recent first)

Date Admitted: \_\_\_\_\_ Duration: \_\_\_\_\_

Name of Facility: \_\_\_\_\_ City: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_ Type of Treatment: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Was treatment completed? \_\_\_\_\_

If no, state reason: \_\_\_\_\_

Duration of Abstinence following Treatment: \_\_\_\_\_

Recommendations or Reports may be requested from the Facility.

**IN-PATIENT** (List most recent first)

Date Admitted: \_\_\_\_\_ Duration: \_\_\_\_\_

Name of Facility: \_\_\_\_\_ City: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_ Type of Treatment: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Was treatment completed? \_\_\_\_\_

If no, state reason: \_\_\_\_\_

Duration of Abstinence following Treatment: \_\_\_\_\_

**IN-PATIENT** (List most recent first)

Date Admitted: \_\_\_\_\_ Duration: \_\_\_\_\_

Name of Facility: \_\_\_\_\_ City: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_ Type of Treatment: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Was treatment completed? \_\_\_\_\_

If no, state reason: \_\_\_\_\_

Duration of Abstinence following Treatment: \_\_\_\_\_

**OTHER HISTORY**  
(photo-copy additional pages if needed.)

Have you had extended medical treatment?  Yes  No

Does the client have a history of psychiatric conditions?  Yes  No

Condition Presented: \_\_\_\_\_

Please give details on date of diagnosis/conditions, and current status, etc. \_\_\_\_\_

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

**A Progress/Assessment Report from the Psychiatrist, Physician, or Mental Health Counsellor/Therapist may be required for any client referred who has mental health condition/diagnosis. Processing of the application may be delayed until such information is received.**

Does client have a history of suicidal ideations/attempts?  Yes  No

If yes, provide details; include dates, method, factor(s) leading to ideation/attempt:

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

In addition, give details of intervention/counselling services provided to the client following the suicidal ideations/attempts:

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

Is the client verbally aggressive?  Yes  No If yes, please give details

\_\_\_\_\_

Is the client physically aggressive?  Yes  No If yes, please give details

\_\_\_\_\_

Does client have a history of incidents of physical aggression?  Yes  No

If yes, please give details:

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

## ADDITIONAL RELATED INFORMATION

Are there any concerns with vision/dental needs? Yes or No. If yes, please describe: \_\_\_\_\_

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Issues / Concerns for which client now seeks treatment:

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Are there any issues or concerns that the client has regarding treatment at the Ngwaagan Gamig Recovery Centre Inc. (Rainbow Lodge)?

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List skills, hobbies, interests, strengths, accomplishments the client is proud of:

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**CLIENT'S CHILDREN**

Child's Name	Age	Gender	Child Resides With	City

Is the Children's Aid Society involved with the client's immediate family?  Yes  No

If yes, please explain order/conditions, include length of C.A.S. involvement, etc.

\_\_\_\_\_

\_\_\_\_\_

Are there conditions that we need to be aware of?  Yes  No

If yes, Please provide. \_\_\_\_\_

## REFERRAL AGENCY

Name of AGENCY: \_\_\_\_\_

Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name of REFERRAL WORKER: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

## PRE-TREATMENT SERVICES

To prepare the client for Residential Treatment Programming, please list the Pre-treatment services that this client will be attending to, include agency, name of worker, type of service provided:

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## AFTERCARE PLANNING

What aftercare & follow-up plans have been made with the client and worker?

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Will any support or counselling be offered to the family while the client is in treatment for recovery/healing initiatives?  YES OR  NO

If yes, describe:

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Any additional comments by Referral Worker:

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The information provided on this Referral Form is true.

Signature of Worker: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Ngwaagan Gamig Recovery Centre Inc.

## PRE-ADMISSION MEDICAL FORM – Revised December 2012

(To be completed by Physician or Nurse Practitioner)

CLIENT'S SURNAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

Sex:  M  F D.O.B.(mm/dd/yr): \_\_\_\_\_ Health Card No: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone: \_\_\_\_\_

I, \_\_\_\_\_ hereby request and consent for my physician to release medical facts and assessments about me to Ngwaagan Gamig Recovery Centre Inc. (Rainbow Lodge) and my referring agency for the purposes of addictions treatment. The photocopy of my signature on this form is as valid as the original.

CLIENT'S SIGNATURE: \_\_\_\_\_ DATED: \_\_\_\_\_

### PRESENT HEALTH CONDITIONS

Heart Disease  Yes  No Diabetes  Yes  No Epilepsy  Yes  No

Pediculosis  Yes  No Communicable Disease  Yes  No

Additional Notes: \_\_\_\_\_

Allergies  Yes  No

If yes, please list: \_\_\_\_\_

Tuberculosis  Yes  No

TB Skin test is now mandatory to be completed prior to entering the treatment program at

Ngwaagan Gamig.

Dates that the Skin test completed: \_\_\_\_\_ Results: \_\_\_\_\_



I hereby certify, that I have examined the above named individual as required, stating this person is free from communicable disease, stabilized, and that this person is physically, mentally, and emotionally able to undertake the program at Ngwaagan Gamig (Rainbow Lodge) Recovery Centre Inc.

Please Print

Name of Physician / Nurse Practitioner: \_\_\_\_\_

Signature of Physician/Nurse Practitioner: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone: \_\_\_\_\_

Ngwaagan Gamig Recovery Centre Inc. is not responsible for any fees associated with completion of this form.

## ITEMS TO BRING TO TREATMENT:

- |   |  |
|---|--|
| Identifying Documents   | - Health Card<br>- Status Card   |
| Toiletries<br>(Must be alcohol-free<br>& no aerosol products) | - Toothpaste, toothbrush<br>- Shampoo / Conditioner<br>- Unscented Deodorant<br>- Hand Soap<br>- Safety Razor<br>- Feminine Products<br>- Comb, brush, curling iron, hair dryer<br>- NO perfume, cologne, body spray |
| Ceremonial Sweat Attire                                       | - Skirt / Cotton night gown<br>- Shorts<br>- Large towel<br>- Bath robe  |

Appropriate Items - Adequate amount of clothing for season / weather, slippers / indoor shoes

**Any art / craft supplies (no toxic materials) and cell phones will be handed in on admitting day. Absolutely NO CD's, cell phones, laptops, iPod's, MP3's and cameras will be allowed during the treatment program.**

## PRESCRIBED MEDICATION

- Bring any prescribed medication(s) in the original container(s) and if available, the “**Drug Fact Sheet**” for each medication, sheet available from your pharmacist.
- If required, ensure you have enough medication for the four weeks in treatment.
- Client must be compliant and stable on his/her prescribed medication or he/she will be requested to return at a later date.

## TRAVELLING INFORMATION:

**IMPORTANT:** Please call to confirm arrival time at bus depot for pick up. Transportation from the closest bus depot to our centre is provided by Ngwaagan Gamig Recovery Centre, as there is no bus from Espanola to Wikwemikong.