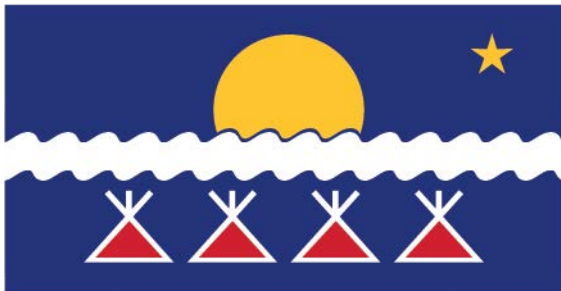


**Tłıchọ Ndek'áowo**



**Tłıchọ Government**

DETOX ON THE LAND  
LAND BASED HEALING  
PROGRAM APPLICATION

Department of Healing  
& Community Wellness

DETOX ON THE LAND  
LAND BASED HEALING

T: 867-392-6381 Ext. 1371  
E: [healing@tlicho.ca](mailto:healing@tlicho.ca)

## **DISCLOSURE**

The information in this application is **confidential** unless you provide written consent for us to share it or unless you pose a risk to yourself or someone else.

The application helps us understand your needs to best determine how we can assist with your path to wellness. Please take the time to complete the application to the best of your ability; the more information you provide, the better. You can fill it in yourself, have someone you know, and trust help you, or call us at the number below to schedule a time to complete it together. There are some sensitive topics, so having a support person with you is recommended.

If you choose not to attend, please notify the Department of Healing and Community Wellness using the contact information below within **48 hours** to allow for the waitlisted participants to attend.

If you are on the waitlist, you will be notified within **24 hours** of the next upcoming session date.

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*Medical Considerations: We are not medically equipped to accommodate individuals on Methadone, Suboxone, Narcotics, Ativan, or any Anti-Psychotic medications.*

*If you are prescribed any diabetic/insulin and supplies, epi-pens, or allergy medications, please bring these with you to site.*

### CONTACT INFORMATION:

#### **Healing & Community Wellness**

Detox on the Land - Land Based Healing Program

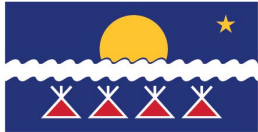
PO Box 412, Behchokò NT X0E 0Y0

127 Donda Tili, Behchokò, NT

T: 867-392-6381 Ext. 1371

E: [healing@tlicho.ca](mailto:healing@tlicho.ca)

Department of Healing & Community Wellness. PO Box 412,  
Behchokò, NT X0E 0Y0 127 Donda Tili, Behchokò, NT ON



**LAND BASED DETOX AND HEALING INTAKE FORM**

<input type="checkbox"/> <b>NEW APPLICANT</b>		<input type="checkbox"/> <b>RETURNING APPLICANT</b>	
<b>A. REFERRAL SOURCE:</b> <i>(If self referring, please skip to section B.)</i>			
First Name:		Last Name:	
Organization Name:			
Address:		City:	Province: Postal Code:
Phone #:		Email:	
Fax #:		If applicable, alternative #:	
<b>Please select one of the following (what is your role in the person's wellbeing?):</b>			
<input type="checkbox"/> Family Physician	<input type="checkbox"/> Child Welfare	<input type="checkbox"/> Probation Officer	
<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Mental Wellness Worker	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Community Service Provider	_____	
<input type="checkbox"/> Suboxone/Methadone Provider	<input type="checkbox"/> Traditional Healer	_____	
<b>B. CLIENT INFORMATION</b>			
First Name:		Last Name:	
Date of Birth: <i>(yyyy/mm/dd)</i>		Gender: M F Other:	
		Preferred Name:	
Address:		City:	Province: Postal Code:
Home Phone: _____		Cell Phone: _____	
Can we leave a message here? Yes No		Can we leave a message here? Yes No	
Email Address:		Contact Preference: Phone Mobile Email	
Status Card Number:		Health Card Number:	
Tłı̨chq Community:		Language Understood:	

**C. DELEGATE INFORMATION** *(If the applicant is completing and is the main contact for referral, please skip to section D.)*

By completing this section, the referral source confirms that the person (“client/applicant”) consents for Department of Healing & Community Wellness to call/email them regarding this referral. The Department of Healing & Community Wellness will refrain from communicating unrequired personal information until consents are verified.

Relationship to Applicant:

Name of Delegate:

1. Phone 1 #:	Email:
2. Phone 2 #:	Preferred Method of Contact: <span style="float: right;">Phone 1 Phone 2      Email</span>

**D. EMERGENCY CONTACT INFORMATION**  
*\*to be contacted in the event of an emergency (ex. Hospitalization)*

Contact Name: _____	Phone Number: _____
Relationship: _____	Email: _____
Contact Name: _____	Phone Number: _____
Relationship: _____	Email: _____

**E. SUPPORT SERVICES**

How many positive supports do you have in your life (including professionals)?

None                  1-3 people                  4-6 people                  7 or more

**Family/Supports:** *(collected for after-care and care planning purposes)*

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

<b>SUPPORT SERVICES contd.</b>	
<b>What support agencies are you involved with in your community?</b> <i>(collected for after-care and care planning purposes)</i>	
Name: _____ Service Provider: _____ Phone Number: _____	Consent for contacting them will be collected during after-care / care planning.
Name: _____ Service Provider: _____ Phone Number: _____	Consent for contacting them will be collected during after-care / care planning.
<b>Care Providers</b> <i>(collected for intake and after-care / care planning purposes)</i>	
<b><u>Doctor/Nurse Practitioner:</u></b>  Name of Provider: _____ Clinic Name: _____ Address: _____ Phone Number: _____  Consent to Contact:            Yes            No	<b><u>Counsellor:</u></b>  Name of Provider: _____ Clinic Name: _____ Address: _____ Phone Number: _____  Consent to Contact:            Yes            No
<b><u>Child Welfare Worker &amp; Agency:</u></b>  Name of Worker: _____ Agency Name: _____ Phone Number: _____ Email: _____  Is treatment part of your service plan?            Yes            No Consent to Contact:            Yes            No	<b><u>Probation/Parole:</u></b>  Name of Officer: _____ Phone Number: _____ Email: _____  Court ordered attendance:            Yes            No Consent to Contact:            Yes            No
<b><u>Other Agency Name:</u></b>  Name of Worker: _____ Agency Name: _____ Address: _____ Phone Number: _____  Consent to Contact:            Yes            No	<b><u>Other Agency Name:</u></b>  Name of Worker: _____ Agency Name: _____ Address: _____ Phone Number: _____  Consent to Contact:            Yes            No



G. PSYCHOSOCIAL HEALTH		
<b>Education</b>		
<b>Level of Education:</b>  <input type="checkbox"/> High school <input type="checkbox"/> Some College/Diploma <input type="checkbox"/> University <input type="checkbox"/> Training	<b>Are you enrolled in school/training?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Program/Courses you're taking:</b>  <hr/> <hr/> <hr/> <hr/>
<b>Employment History</b>		
<b>Are you currently employed?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Type of employment:</b>  <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Casual	<b>Current Employer:</b>  <hr/> <hr/> <hr/>
<b>Social</b>		
<b>Source of Income:</b>  <input type="checkbox"/> Employment <input type="checkbox"/> Employment Insurance <input type="checkbox"/> Workers Safety Insurance Plan (WSIB) <input type="checkbox"/> Old Age Pension <input type="checkbox"/> Canadian Pension Plan <input type="checkbox"/> Social Assistance <input type="checkbox"/> Other: _____ _____ _____		

*People who are seeking services often struggle with mental health and learning differences. To plan for your success, let us know your history of mental health and learning differences, and check the box that best describes the impact of issue.*

	Do you experience		Formally diagnosed		Age it started	Minor impact	Moderate serious	Major impact
<b>Anxiety</b>	Yes	No	Yes	No				
<b>Depression</b>	Yes	No	Yes	No				
<b>Bipolar Disorder</b>	Yes	No	Yes	No				
<b>Eating Disorder</b>	Yes	No	Yes	No				
<b>Obsessive Compulsive Disorder</b>	Yes	No	Yes	No				
<b>Post-Traumatic Stress Disorder</b>	Yes	No	Yes	No				
<b>Schizophrenia</b>	Yes	No	Yes	No				
<b>Social Phobia</b>	Yes	No	Yes	No				
<b>Attention Deficit Disorder</b>	Yes	No	Yes	No				
<b>Fetal Alcohol Effects / Spectrum</b>	Yes	No	Yes	No				
<b>Psychosis</b>	Yes	No	Yes	No				
<b>Oppositional Defiant Disorder (ODD)</b>	Yes	No	Yes	No				
<b>Learning Disability (not ADD/ADHD)</b>	Yes	No	Yes	No				
<b>Have you thought about suicide?</b>	Yes	No						
<b>Have you ever attempted suicide?</b>	Yes	No						
<b>Other:</b>			Yes	No				

If you answered yes to any of the above questions, please tell us any coping strategies you use to help with these issues: \_\_\_\_\_

\_\_\_\_\_

#### H. LEGAL

Do you have a criminal record?	Yes	No
Current Charges:		
Court Date:		

#### I. FOUR SPHERES ASSESSMENT

Thinking about your life in the last 3 months, circle the most appropriate response to the right:	Very Poor	Poor	OK	Good	Excellent
Physical Health	VP	P	OK	G	E
Emotional Wellness	VP	P	OK	G	E
Mental Wellness	VP	P	OK	G	E
Spiritual Wellness	VP	P	OK	G	E



J. SUBSTANCE INVOLVEMENT						
Please tell us about your use of drugs and alcohol over the last 3 months (90 days)			Age started?	How often?	Last used?	Route
METHADONE, SUBOXONE or SUBLOCADE	Yes	No				
ALCOHOL	Yes	No				
TOBACCO (cigarettes/vape)	Yes	No				
MARIJUANA	Yes	No				
POWDER COCAINE	Yes	No				
or ROCK COCAINE	Yes	No				
INHALANTS (glue, gasoline, etc.)	Yes	No				
METH/AMPHETAMINES (ecstasy, MDMA, speed)	Yes	No				
TRANQUILIZERS not prescribed (benzos, ludes, valium, goofballs, roofies, Prozac)	Yes	No				
BARBITUATES (barbs, downers, sleepers, reds)	Yes	No				
FENTANYL	Yes	No				
KETAMINE ("k")	Yes	No				
OPIATES (heroin, morphine, oxy, perc's, hydro, codeine)	Yes	No				
HALLUCINOGENS (mushrooms, Datura, LSD, peyote)	Yes	No				
PCP (angel dust)	Yes	No				
OVER THE COUNTER MEDS (cough syrup, pain relievers, antihistamines)	Yes	No				
PRESCRIPTION DRUG(S) NOT PRESCRIBED (ex. OxyContin, Ritalin) Which one: _____	Yes	No				
OTHER DRUGS: _____						
Which substance(s) do you use the most? _____						
Which is your substance of choice (if you had access?) _____						
Do you experience Psychosis?      No                      Yes                      If yes, how often? _____						
<b>*Use acronym in modality section*</b>						
(IV) – injecting (PO) – by mouth: inhalants, vaping, smoking (PR) – per rectal (PV) – per vaginal (SN) – snorted						

<b>K. HOUSING</b>			
Do you currently have stable housing?	Yes	No	
Do you consider this your home?	Yes	No	
If not, where do you consider your home?			
If not, what is your living arrangement?			
Do you have a safe place to go after Detox/Healing?	Yes	No	
Are you houseless?	Yes	No	
How many people in the home?			
What are your sleeping arrangements?			
How many hours of sleep do you get a night?			
<b>L. FAMILY HISTORY/CULTURAL INFORMATION</b>			
Did any of your family members attend residential school?	Yes	No	Not sure
Were you, your parents, or grandparents involved with Child Welfare System?	Yes	No	Not sure
Are you aware of impacts of colonization?	Yes	No	Not sure
Do you feel connected to your cultural identity?	Yes	No	Not sure
Have you practiced any traditional teachings?	Yes	No	Not sure
Have you practiced any spiritual, religious teachings or practices (ex., ceremonies, church, smudging, fasting, etc.)	Yes	No	Not sure
Are there any specific spiritual practices that are important to you? <i>If yes, please describe:</i>	Yes	No	Not sure
Is there anything else you would like for us to know about you? <i>Please tell us here.</i>			
What other Services/Supports do you require after the Land Based Detox and Healing? <i>Please describe.</i>			
Would you be interested in attending a mainstream treatment program?	Yes	No	
Would you be interested in an After Care/Relapse Prevention Program?	Yes	No	
Have you lost a loved one, friend, relative, or pet? How long ago?			
<b>M. CONSENT</b>			
<b>Completed By:</b>			
<b>Signature:</b>			
<b>Date:</b>			