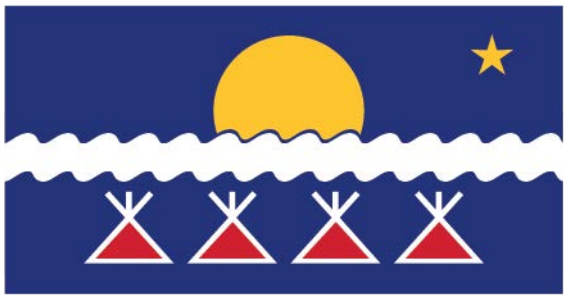
Tłı̨chǫ Ndek'àowo



Tłı̨chǫ 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. 1423
E: lena.moosenose@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.

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, Behchokǫ̀ NT X0E 0Y0
127 Donda Tili, Behchokǫ̀, NT
T: 867-392-6381 Ext. 1371
E: healing@tlicho.ca

Tłı̨chǫ Ndek'àowo
Tłı̨chǫ Government

Healing & Community
Wellness 127 Donda Tili,
Behchokǫ̀ , NT
T: 867-392-6381 Ext. 1371
healing@tlicho.ca

LAND BASED DETOX AND HEALING INTAKE FORM

☐ NEW APPLICANT	☐ RETURNING APPLICANT

A. REFERRAL SOURCE: *(If self referring, please skip to section B.)*

First Name:	Last Name:		
Organization Name:			
Address:	*City:*	*Province:*	*Postal Code:*
Phone #:	Email:		
Fax #:	If applicable, alternative #:		

Please select one of the following (what is your role in the person's wellbeing?):

- ☐ Family Physician
- ☐ Nurse Practitioner
- ☐ Social Worker
- ☐ Suboxone/Methadone Provider
- ☐ Child Welfare
- ☐ Mental Wellness Worker
- ☐ Community Service Provider
- ☐ Traditional Healer
- ☐ Probation Officer
- ☐ Other: _____
  _____
  _____

B. CLIENT INFORMATION

First Name:	Last Name:		
Date of Birth: (yyyy/mm/dd)	Gender: ☐ M ☐ F ☐ Other:		
	Preferred Name:		
Address:	*City:*	*Province:*	*Postal Code:*
Home Phone: _____ Can we leave a message here? ☐ Yes ☐ No	Cell Phone: _____ Can we leave a message here? ☐ Yes ☐ No		
Email Address:	Contact Preference: ☐ Phone ☐ Mobile ☐ Email		
Status Card Number:	Health Card Number:		
Tłı̨chǫ 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: ☐ Phone 1 ☐ Phone 2 ☐ Email

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

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

SUPPORT SERVICES contd.

What support agencies are you involved with in your community?

(collected for after-care and care planning purposes)

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.

Care Providers

(collected for intake and after-care / care planning purposes)

Doctor/Nurse Practitioner: Name of Provider: _____ Clinic Name: _____ Address: _____ Phone Number: _____ Consent to Contact: ☐ Yes ☐ No	**Counsellor:** Name of Provider: _____ Clinic Name: _____ Address: _____ Phone Number: _____ Consent to Contact: ☐ Yes ☐ No
Child Welfare Worker & Agency: Name of Worker: _____ Agency Name: _____ Phone Number: _____ Email: _____ Is treatment part of your service plan? ☐ Yes ☐ No Consent to Contact: ☐ Yes ☐ No	**Probation/Parole:** Name of Officer: _____ Phone Number: _____ Email: _____ Court ordered attendance: ☐ Yes ☐ No Consent to Contact: ☐ Yes ☐ No
Other Agency Name: Name of Worker: _____ Agency Name: _____ Address: _____ Phone Number: _____ Consent to Contact: ☐ Yes ☐ No	**Other Agency Name:** Name of Worker: _____ Agency Name: _____ Address: _____ Phone Number: _____ Consent to Contact: ☐ Yes ☐ No

F. MEDICAL HISTORY

When was the last time you had a medical or regular visit with your doctor to discuss your health?

☐ In the last 3 months ☐ 4-12 months ago ☐ 1-5 years ago ☐ over 5 years ago

In the last 3 months, how many times did you visit a hospital emergency room?

☐ None ☐ once ☐ 2-3 times ☐ 4-5 times ☐ more than 20 times

Do you have any medical concerns that we should be aware of that may impact your ability to take part in the land-based detox program?

☐ No ☐ Yes

If yes, please describe: _____

_____

_____

_____

Do you have any allergies?

Do you require an epi-pen or allergy medication for reactions?

Are you a diabetic?

Do you have high blood pressure?

Have you tested positive for Hep C, Hep B, or HIV?

If yes, _____

Do you have any symptoms of COVID-19?

Please list any prescription, non-prescription or herbal medications you are currently taking:

Name	Dose	Frequency	Route (ie., mouth, injections, etc.

***Please bring all your medications with you, including any epi-pens.**

G. PSYCHOSOCIAL HEALTH

Education

Level of Education:	Are you enrolled in school/training?	Program/Courses you're taking:
☐ High school ☐ Some College/Diploma ☐ University ☐ Training	☐ Yes ☐ No	_____ _____ _____ _____

Employment History

Are you currently employed?	Type of employment:	Current Employer:
☐ Yes ☐ No	☐ Full time ☐ Part time ☐ Seasonal ☐ Casual	_____ _____ _____

Social

Source of Income:

☐ Employment	☐ Old Age Pension	☐ Other: _____
☐ Employment Insurance	☐ Canadian Pension Plan	_____
☐ Workers Safety Insurance Plan (WSIB)	☐ Social Assistance	_____

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
Anxiety	Yes or No	Yes or No				
Depression	Yes or No	Yes or No				
Bipolar Disorder	Yes or No	Yes or No				
Eating Disorder	Yes or No	Yes or No				
Obsessive Compulsive Disorder	Yes or No	Yes or No				
Post-Traumatic Stress Disorder	Yes or No	Yes or No				
Schizophrenia	Yes or No	Yes or No				
Social Phobia	Yes or No	Yes or No				
Attention Deficit Disorder	Yes or No	Yes or No				
Fetal Alcohol Effects / Spectrum	Yes or No	Yes or No				
Psychosis	Yes or No	Yes or No				
Oppositional Defiant Disorder (ODD)	Yes or No	Yes or No				
Learning Disability (not ADD/ADHD)	Yes or No	Yes or No				
Have you thought about suicide?	Yes or No					
Have you ever attempted suicide?	Yes or No					
Other:		Yes or 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	Choose one:				
Emotional Wellness	Choose one:				
Mental Wellness	Choose one:				
Spiritual Wellness	Choose one:				

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 or No				
ALCOHOL	Yes or No				
TOBACCO (cigarettes/vape)	Yes or No				
MARIJUANA	Yes or No				
POWDER COCAINE	Yes or No				
or ROCK COCAINE	Yes or No				
INHALANTS (glue, gasoline, etc.)	Yes or No				
METH/AMPHETAMINES (ecstasy, MDMA, speed)	Yes or No				
TRANQUILIZERS not prescribed (benzos, ludes, valium, goofballs, roofies, Prozac)	Yes or No				
BARBITUATES (barbs, downers, sleepers, reds)	Yes or No				
FENTANYL	Yes or No				
KETAMINE (“k”)	Yes or No				
OPIATES (heroin, morphine, oxy, perc’s, hydro, codeine)	Yes or No				
HALLUCINOGENS (mushrooms, Datura, LSD, peyote)	Yes or No				
PCP (angel dust)	Yes or No				
OVER THE COUNTER MEDS (cough syrup, pain relievers, antihistamines)	Yes or No				
PRESCRIPTION DRUG(s) NOT PRESCRIBED (ex. OxyContin, Ritalin) Which one: _____	Yes or 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? _____

Use acronym in modality section

(IV) – injecting **(PO)** – by mouth: inhalants, vaping, smoking
(PR) – per rectal **(PV)** – per vaginal **(SN)** – snorted

K. HOUSING			
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?			
L. FAMILY HISTORY/CULTURAL INFORMATION			
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? *If yes, please describe:*	☐ Yes	☐ No	☐ Not sure
Is there anything else you would like for us to know about you? *Please tell us here.*			
What other Services/Supports do you require after the Land Based Detox and Healing? *Please describe.*			
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?			

M. CONSENT	
Completed By:	
Signature:	
Date:	