

BEHAVIOURAL HEALTH FOUNDATION

Application for Admission

Men's, Women's & Family Addictions and Co-occurring Disorder Treatment Services

(To be completed by referring agency worker or individual at time of referral)

Date: _____

Referring Agent's Name: _____

Agency: _____

Address: _____

Phone: _____

Name of Referral: _____

Address: _____

Phone: _____

Date of Birth (month/day/year): _____ / _____ / _____ Sex: M _____ F _____

Medical #: _____ Treaty # & Band: _____

S.I.N. #/Security #: _____ Languages: _____

Ethnic Origin: _____

Presenting Problem: (check all that are applicable)

Alcohol ___ Solvents ___ Drugs ___ Other ___ (Please specify) _____

Next of Kin in Case of Emergency:

Name: _____

Address: _____

Phone #: _____ Relationship: _____

Marital Status: Single ___ Married ___ Common-law ___ Separated/Divorced ___

If married, name of spouse: _____

List Children: (please provide the most current school report card for each child prior to entry)

Name: _____ Date of Birth (month/day/year): _____ / _____ / _____ Sex _____

Grade: _____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

Name: _____ Date of Birth (month/day/year): _____ / _____ / _____ Sex _____

Grade: _____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

Name: _____ Date of Birth (month/day/year): _____ / _____ / _____ Sex _____

Grade: _____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

Name: _____ Date of Birth (month/day/year): ____/____/____ Sex ____

Grade: ____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

Are child(ren) in care of a child care agency: Yes ____ No ____

If yes, which child(ren)? _____

How long have they been in care? _____ How long are they expected to stay in care? _____

What type of order is in place? (i.e. VPA, Permanent, Temporary, Supervision) _____

What agency are child(ren) in care of: _____

Worker's Name: _____

Address: _____

Health of Referral: (i.e. allergies, physically or mentally disabled, general state)

Is referral on any medication? Yes ____ No ____ If yes, list: _____

Has referral ever been given a mental health diagnosis by a qualified health professional?

Yes ____ No ____

If yes, list diagnosis and name and location of professional. _____

When were you diagnosed? _____

Has referral ever been hospitalized for a mental health related illness? Yes ____ No ____

If yes, when, where and for which illness? _____

Has referral ever harmed self or thought of harming self but not as a direct result of alcohol or other drug use? Yes ____ No ____

If yes, list all incidents. _____

Please provide a detailed description of problems that are occurring within the family unit. Include any issues related to family violence and past or present domestic assault charges.

Previous involvement in treatment facilities:

Name of Facility: _____

Approximate Date: _____

Work Experience: _____

Education: _____

Previous Criminal Record: _____

Is referral facing any criminal charges? Yes _____ No _____

If yes, list: _____

Has referral ever been charged with sexual assault or other sexual offences? Yes _____ No _____

If yes, explain: _____

Has referral ever been charged with arson/setting fires? Yes _____ No _____

If yes, explain: _____

Has referral ever been charged with any crimes against children? Yes _____ No _____

If yes, explain: _____

Is referral on probation? Yes _____ No _____

If yes, give name and address of Probation Officer: _____

Is referral on parole? Yes _____ No _____

If yes, give name and address of Parole Officer: _____

Please provide a Social History if available. Send with the completed application form.

Does referral have a bank account? Yes _____ No _____

If yes and you intend to be funded by Employment and Income Assistance you are required to provide bank statements for the 2 months prior to entry.

Funding Source: _____

Address: _____

Phone #: _____

For Out of Country Referrals Only:

Does referral carry private health care insurance? Yes _____ No _____

If yes, what is the name of the health care provider and policy name and number?

If no, is the referral agency prepared to cover health care costs that may be incurred during the treatment stay? Yes _____ No _____

TO BE COMPLETED BY PERSON SEEKING TREATMENT

1. I understand that upon entry to BHF I am to bring either a current prescription and a method of payment, or a minimum 2 week supply of all medications, otherwise I will be without medication during my initial stay.
2. I agree to undergo treatment at the Behavioural Health Foundation and believe all of the information in this referral is correct.

Signature of person being referred

Date

**Please mail or fax this form to:
Behavioural Health Foundation
Box 250, 35 ave de la Digue
St. Norbert, MB R3V 1L6
Fax: (204) 269-8049
Phone: (204) 269-3430**

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Is referral suitable for placement? Yes _____ No _____

If unacceptable, document reason: _____

Were recommendations for alternative services made? Yes _____ No _____

If yes, what were they? _____

Follow up info: _____

Staff signature: _____