BEHAVIOURAL HEALTH FOUNDATON
Application for Admission
Men's, Women's & Family Addictions and Co-occurring Mental Health Treatment Services
(To be completed by adult wanting treatment, or by referring agency worker on client's behalf)

Date: _____

Referring Agent's Name: _____
Agency: _____
Address: _____
Phone: _____

Lawyer's Name: _____ Phone: _____
(if applicable)

Applicant's name: _____

Address: _____

Phone: _____

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

Medical #: _____ Treaty # & Band: _____

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

Ethnic Origin: _____

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

If married, name of spouse: _____

List Children: (if entering BHF with 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: _____

Next of Kin in Case of Emergency:

Name: _____

Address: _____

Phone #: _____ Relationship to you: _____

Presenting Problem: (check all that are applicable to you)

Alcohol ___ Solvents ___ Drugs ___ (Please specify) _____

Other ___ (Please specify) _____

Applicant's health: (i.e. allergies, physically or mentally disabled, general state)

_____

_____

Are you on any prescribed medication? Yes ☐ No ☐ If yes, list: _____

_____

Have you been diagnosed, or ever experienced any of the following:

Major Depression	Yes ☐ No ☐	Schizophrenia	Yes ☐ No ☐
Bi-Polar	Yes ☐ No ☐	Other Mental Health	Yes ☐ No ☐
Major Anxiety Disorder	Yes ☐ No ☐		

Are you currently experiencing suicidal ideation? Yes ☐ No ☐

Have you 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? _____

Have you ever been hospitalized for a mental health related illness? Yes ☐ No ☐

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

Have you ever harmed yourself or thought of harming yourself, but not as a direct result of alcohol or other drug use? Yes ☐ No ☐

If yes, list all incidents. _____

Have you ever suffered any significant trauma? Yes ☐ No ☐

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

_____

_____

Please describe your current housing or homelessness situation:

_____

_____

Previous involvement in addiction and/or mental health treatment facilities:

Name of Facility: _____

Approximate Date: _____

Work Experience: _____

_____

Education: (last grade completed, further education, etc.) _____

_____

Previous Criminal Record: _____

_____

Are you facing any criminal charges? Yes ☐ No ☐

If yes, list: _____

_____

Have you ever been charged with sexual assault or other sexual offences? Yes ☐ No ☐

If yes, explain: _____

_____

Have you ever been charged with arson/setting fires? Yes ☐ No ☐

If yes, explain: _____

_____

Have you ever been charged with any crimes against children? Yes ☐ No ☐

If yes, explain: _____

_____

Are you on probation? Yes ☐ No ☐

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

_____

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

Do you have a bank account? Yes ☐ No ☐

Are you presently funded by Employment and Income Assistance? Yes ☐ No ☐

BHF provides services through funding agreements with government departments for Manitobans who do not have the ability to pay for addiction treatment services. Persons who have a source of income, ie: employment, employment insurance, pension or disability benefits, etc., are required to pay a monthly room and board rate. Out of province referrals are required to pay per day rates. BHF's Intake Worker assists in providing detailed information regarding funding/fees upon request.

Funding Source: _____

Address: _____

Phone #: _____

For Out of Country Referrals Only:

Do you 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 understand that if I am a suitable candidate for the BHF program, I can name a supportive family member/support person who may be called upon during my treatment stay to assist as necessary. I also understand that it is acceptable not to involve a support person in my treatment if I choose.

   Choose one option:

   ☐ BHF has my consent to contact the following person for the purpose of supporting me throughout my treatment stay. I may revoke this consent at any time by indicating that in writing to my Keyworker.

   Name: _____ Relationship to me: _____

   Best way to contact: Address: _____

   Phone: _____ Email: _____

   ☐ I do not wish to have an external support person during my treatment stay.
   Signed: _____ Date: _____

3. I agree to undergo treatment at the Behavioural Health Foundation and believe all of the information in this referral is correct.

   _____ _____

   Applicant's signature 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

FOR BEHAVIOURAL HEALTH FOUNDATION USE ONLY

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: _____

MEDICAL CLEARANCE FOR TREATMENT

The individual noted below has requested entry to residential addiction and co-occurring mental health treatment services at the Behavioural Health Foundation. Please assess, and provide all of the information requested. BHF is a trustee under the Personal Health Information Act.

MUST BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER

(Please Print Clearly)

Patient's name:		Date:
PHIN #:	MHSC#:	Date of Birth:
Doctor's name:	Hospital/Medical Clinic:	
Blood Pressure:	Pulse:	Respirations:
Has client been checked for lice and scabies? Yes ☐ No ☐ Is treatment required? Yes ☐ No ☐		
Is client currently pregnant? Yes ☐ No ☐		

Client's active medical concerns:	Client's inactive medical concerns:

Client medication information

All client medications must be documented below. All medications need to be properly packaged, including client name, physician name, pharmacy, dosage amounts and time(s) of administration, and the date of prescription issue.
How effective have these medications been?

Was client provided with a prescription today? Yes ☐ No ☐
Name of medication? Dosage:
Medical clearance: _____ cleared to participate in BHF programming _____ not cleared to participate in BHF programming Reason: _____ ❑ *I understand if referral fails to bring either a current prescription and a method of payment, or a minimum 2 week supply of all medications, he/she will be without medication during her/his initial stay.* ❑ *I will be providing primary medical/mental health care for this client as needed during his/her treatment at BHF (name, address and phone number)* _____ *or* ❑ *The following Physician or Nurse Practitioner will be providing primary medical/mental health care for this client during treatment at BHF (name, address and phone number)* _____
Physician Comments:

Physician Signature: _____ Date Issued: _____