

BEHAVIOURAL HEALTH FOUNDATION
Breezy Point Program
Application for Admission

(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: (if applicable)	_____ Phone: _____

Applicant's name: _____

Address: _____

Phone: _____

Date of Birth (month/day/year): ____/____/____ Sex: F ____ Other ____

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, 35B ave de la Digue
St. Norbert, MB R3V 1L6
Fax: (204) 275-2099
Phone: (204) 261-6111**

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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: _____