BEHAVIOURAL HEALTH FOUNDATION
Application for Admission

Check preference:

☐ Addiction Treatment Services ☐ Breezy Point (women's program) ☐ Either Program, wherever space is available first

(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: _____

Email: _____

Date of Birth (month/day/year): _____ /_____/_____ Sex: M_____F_____ Other _____
(does not identify by traditional gender definitions)

Medical # (6 digit): _____ PHIN # (9 digit): _____

Do you have Treaty Status: Yes ☐ No ☐ Treaty # & Band Name: _____

S.I.N. #: _____Languages: _____

Ethnic Origin: _____

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

If married, name of spouse: _____

List Children:

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: _____

If entering BHF with children, please provide the most current school report card for each child prior to entry.

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 ___ List: _____

Other ___ List: _____

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

_____

_____

_____

Are you pregnant? Yes ☐ No ☐ If yes, estimated due date: _____

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

_____

_____

_____

Have you ever experienced any of the following:

Major Depression Yes ☐ No ☐

Bi-Polar Yes ☐ No ☐

Major Anxiety Disorder Yes ☐ No ☐

Schizophrenia Yes ☐ No ☐

Other Mental Health 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: _____

_____

_____

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 the full cost for addiction treatment services. However, program participants are required to pay monthly room and board rates. BHF's Intake Worker assists in providing detailed information regarding funding/fees. Out of province referrals are required to pay per day rates.

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 I am required to have my doctor complete a "Medical Clearance for Treatment" form within one week of entering the BHF program. I understand that the Medical and Medication information provided on this form, must be consistent with the Medical Clearance form or it will delay my entry into BHF treatment.
2. I understand that upon entry to BHF, if I am on prescribed medication, I am to bring either a current prescription and a method of payment, or a minimum 2 to 4 week supply of all medications. If I do not do either, I will be without medication during my initial stay.
3. I hereby provide consent to BHF staff to discuss my Application for Admission and program suitability with the Referring Agent and/or Lawyer named on page 1 of this Application.
4. 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 (a) or (b):
   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.

a) Name: _____Relationship to me: _____

   Best way to contact: Address: _____

   Phone: _____ Email: _____

b) I do not wish to have an external support person during my treatment stay.

   Signed: _____ Date: _____

5. I agree to undergo treatment at the Behavioural Health Foundation and have read numbers 1-3 above, and believe all of the information in this Application for Admission is correct and true.

_____ _____
Applicant's signature Date

Please mail or fax this form to:

Addiction Treatment Services
Box 250, 35 ave de la Digue
St. Norbert, MB R3V 1L6
Fax: (204) 269-8049
Phone: (204) 269-3430 Ext: 131

OR

Breezy Point (women's program)
Box 250, 35B ave de la Digue
St. Norbert, MB R3V 1L6
Fax: (204) 275-2099
Phone: (204) 261-6111 (Intake)

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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: _____