



Application for Admission

Application Requirements

1. Application form completed and signed by client
2. Referring person (if applicable) complete page seven
3. Medical doctor must complete medical assessment on pages eight to eleven

Admission Criteria

1. All legal, medical, education, employment, and child care services must be dealt with prior to admission so as not to interfere with your treatment program.
2. Remain alcohol and drug free for 72 hours prior to admission date
3. Clients stabilized on a current methadone/suboxone program are approved on a case-by-case basis; please contact the Admissions department.

Financial Requirements

1. Alberta clients: (must provide a current and valid Alberta Health Care number on the application form): Treatment service charge of \$40 per day. Must have an agency providing funding confirmation OR if self paying, payment for the full amount 1 week prior to admission for treatment.
2. For clients outside Alberta: Treatment service charge of \$150 per day. Must have an agency providing funding confirmation OR if self paying, payment for the full amount 1 week prior to admission for treatment.
3. For clients outside of Canada: Treatment service charge of \$250 per day. Must have an agency providing funding confirmation OR if self paying, payment for the full amount 1 week prior to admission for treatment.

Return all 10 pages by mail, email to admissions@poundmaker.org, or by fax to our Admissions department at fax 780-459-1876. Unanswered questions, incomplete or illegible answers may delay your admission.

What Program Are you Applying For? (only check one box)			
<input type="checkbox"/> 42 Day Drug/Alcohol Program		<input type="checkbox"/> 42 Day Gambling Program	
<input type="checkbox"/> 14 Day Follow up Program * (must have previously completed a residential treatment program and have maintained sobriety since completion)		<input type="checkbox"/> Iskwew Healing Lodge	
Legal Name (last, first, middle)			
Other name used:		Other Last Name Used:	
Date of Birth (yyyy-mm-dd)	Health Care Number	Age	<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> transgender



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Mailing Address:	City/Town:
Province:	Postal Code:
Home Phone:	Cell Phone:
Marital Status (please check one box only) <input type="checkbox"/> Single/Never married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Ethnicity <input type="checkbox"/> Status <input type="checkbox"/> Métis <input type="checkbox"/> Non-Aboriginal <input type="checkbox"/> Non-status <input type="checkbox"/> Inuit	
Treaty Status <input type="checkbox"/> Status <input type="checkbox"/> Métis Band Name: _____ 10 digit Treaty number: _____	
Education level achieved:	Occupation:
Next of Kin to be notified in case of emergency	Relationship to applicant
Phone Number	Full Address
If prescriptions or ambulance services are required, how will they be paid for? (AB Works, Blue Cross, Health Canada, etc?)	
Health Coverage Provider	Health Coverage Number

Legal Matters

- * all legal matters must be dealt with prior to admission so as not to interfere with your treatment.
- * all legal documents must be submitted along with application form

Would you be coming to treatment under one of the following conditions?	
<u>Federal</u>	
<input type="checkbox"/> Parole* <i>please complete below</i>	<input type="checkbox"/> Statutory Release
<u>Provincial</u>	
<input type="checkbox"/> Probation* <i>please complete below</i>	<input type="checkbox"/> Recognizance <input type="checkbox"/> Conditional Sentencing Order
<input type="checkbox"/> Temporary Absence* <i>please complete below</i>	



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Type of Offence	Name of Parole/Probation Officer
Parole/Probation Officer's Phone	Parole/Probation Officer's Agency/Office
<u>Other</u> <input type="checkbox"/> Child Welfare <input type="checkbox"/> Employment Reasons	
If you have a history of criminal convictions, list the type and approximate dates of conviction(s) <hr/> <hr/> <hr/>	
Are there other concerns you feel we should know? <hr/> <hr/> <hr/>	

Please describe in detail your alcohol, other drug use and/or gambling

Regular Substance
What do you use most often?
Pattern of use (eg. daily, binge)
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? (yyyy-mm-dd)
Other Substance Used
What other drug do you use?
Pattern of use (eg. daily, binge)
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? (yyyy-mm-dd)



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Other
What other drug do you use?
Pattern of use (eg. daily, binge)
How long have you used this substance?
How long has this been a problem for you?
Date you last used this substance? (yyyy-mm-dd)
Gambling
Types of gambling done? (VLT, bingo, horse gambling)
Pattern of gambling (e.g. daily, weekends, paydays)
Amount of money gambled per occasion
How long have you gambled?
How long has this been a problem for you?
Date you last gambled (yyyy-mm-dd)
Describe in detail how your drinking, drug taking and/or gambling affected you and your life? (e.g. effects on family, relationships, employment, health, social life, etc.)

Treatment history for alcohol, drug or gambling problems
Have you previously attended a treatment centre for addictions and/or gambling? And if so, which one(s) and when?
Reason(s) for previous treatment
Approximate date(s)



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How long did you remain, alcohol, drug or gambling free after treatment?
What are your reasons for wanting to attend residential treatment at this time?
Do you have any special needs or problems that we need to be aware of? (<i>reading and writing English, wheelchair accessibility, hearing difficulties, problem with stairs and long corridors</i>)
<input type="checkbox"/> No
<input type="checkbox"/> Yes, give details
List all medications that you are taking, including all over-the-counter drugs. (<i>e.g. Graval, Tylenol, NyQuil, allergy medications, vitamins, herbal remedies, etc.</i>)
Are you seeing a doctor regularly for any reason, including refilling medication?
<input type="checkbox"/> No
<input type="checkbox"/> Yes, explain
Describe current medical problems (e.g. chronic health issues, recent surgery, injuries, pain, etc.)
Have you ever experienced mental health concerns? (<i>e.g. panic attacks, hallucinations/delusions, uncontrollable rage, mood swings, mental illness, etc.</i>)
<input type="checkbox"/> No
<input type="checkbox"/> Yes, what are the problems?
Describe in detail how the above problems affected you or others both in the past and currently



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If currently under the care of a doctor/psychiatrist/psychologist, complete boxes below ↓	
Name	Phone Number
Name	Phone Number
Have you had any thoughts of suicide or self harm? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe in detail <hr/> <hr/>	
Check method of payment <input type="checkbox"/> Cash <input type="checkbox"/> Certified Cheque <input type="checkbox"/> Money Order <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> SFI/ AB Works/ AISH (Assured Income for Severely Handicapped) If checked, provide 3 rd part contact information Name: _____ Organization: _____ Phone Number: _____ Fax Number: _____ <input type="checkbox"/> Health Canada/ NNADAP If checked, provide 3 rd party contact information Name: _____ Organization: _____ Phone Number: _____ Fax Number: _____ <input type="checkbox"/> Other (<i>explain, ex Labour Unions</i>) _____ If checked, provide 3 rd party contact information Name: _____ Organization: _____ Phone Number: _____ Fax Number: _____	
Carefully Read the Following: <ul style="list-style-type: none"> I understand in order to be admitted to residential treatment, I must remain alcohol and drug free for at least 72 hours prior to my admission date. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be referred to a detoxification setting before treatment. I understand Poundmaker's Lodge is not responsible for personal costs I may incur (e.g. approved medications) while I am in treatment. I understand I cannot schedule any appointments (legal, dental, medical, or personal) for the period while in treatment. I must focus on my treatment program. I understand and agree to accept and attend all components of the treatment program as prescribed by Poundmaker's Lodge including all lectures, 12 step meetings leisure and group counseling sessions 	
Signature	Date (yyyy-mm-dd)



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Waiver To Release Information

I, _____ authorize

- a) My referrals as listed on this application form to release to Poundmaker's Lodge Treatment Centres any information, including but not limited to, medical diagnosis, psychological and/or psychiatric assessments and evaluations pertaining to my treatment at the aforementioned centre;

Signature	Date (yyyy-mm-dd)
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I, _____ authorize Poundmaker's Lodge to transfer my prescriptions from my current pharmacy to Halls Pharmacy, Poundmaker's Lodge pharmacy in Edmonton, for the duration of my stay at Poundmaker's Lodge. I will bring a 2 day supply of my medications with me and will be provided with the remainder of medications by Poundmaker's Lodge.

Signature	Date (yyyy-mm-dd)
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In Office Use

<input type="checkbox"/> application approved	
<input type="checkbox"/> application not approved reason: _____	
Signature	Date



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Please note that all referrals must be on a professional basis; referrals from friends and family are not accepted.

☐ Self-Referral, skip this section

This section is to be completed by the referring person only				
Referring Person's Name				
Agency		Professional relationship to applicant		
Business Address		City	Province	
Postal Code	Email	Phone Number	Fax Number	
Type of Referral (<i>check the box which most applies</i>) <input type="checkbox"/> AHS Addiction Services <input type="checkbox"/> Health/Medical- Doctor <input type="checkbox"/> Business/Workplace, specifically: <input type="checkbox"/> Other Addictions Agency <input type="checkbox"/> Health/Medical- other <input type="checkbox"/> EAP <input type="checkbox"/> Mental Health <input type="checkbox"/> WCB/ Disability Management <input type="checkbox"/> Human Resources <input type="checkbox"/> Justice/legal <input type="checkbox"/> Private Employer <input type="checkbox"/> Other (<i>specify</i>) _____				
What is your assessment of the applicant's readiness and motivation for residential treatment? _____ _____ _____ _____ _____ _____				
Other than alcohol, drug or gambling, what issues does the applicant need to address while in the program? _____ _____ _____ _____ _____				
Referral's Signature			Date (yyyy-mm-dd)	



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This medical assessment is required as part of the application and must be completed in full by a medical doctor.

Patient Name (last, first, initial)		Date of Birth (yyyy-mm-dd)		Personal Health Care Number		
Allergies (e.g. drug, food, latex, other)			Special Dietary Requirements			
Review of Systems (please send relevant reports, e.g. CBC, hepatic profile, electrolytes, urinalysis, etc)						
EENT						
Respiratory (e.g. asthma, COPD)			Cardiovascular (e.g. CVA, MI, HTN, arrhythmia, pacemaker)			
Gastrointestinal (eg GERD, history GI bleed, hepatitis, pancreatitis)			Genitourinary (eg incontinence, BPH, STD)			
Musculoskeletal (eg chronic pain, RA, OA, gout)			Integumentary (eg psoriasis, eczema)			
Neurological Does the patient have a history of seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes			Hematological/Immune (e.g. HIV+, HCV+)			
Evidence of withdrawal or intoxication? (eg ETHO, OPIOID)			Other (specify)			
Physical Examination						
Height	Weight	Temperature	Pupils	Heart rate	Blood Pressure	Respiration rate
Skin		Diaphoresis		Tremor		
Is the patient diabetic? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete this information →				Year Diagnosed	Is the patient stable? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Does the patient have MRSA and wound? <input type="checkbox"/> No <input type="checkbox"/> Yes, (specify latest swab results) _____				Is there cognitive impairment? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Needs assistance ambulating or providing self care? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Pregnancy						
Is the patient pregnant? <input type="checkbox"/> No, complete top boxes only → <input type="checkbox"/> Yes, complete all boxes		LMP		Para		Gravida
		EDC	Urine hCG	Prenatal blood work	Prenatal ultrasound	Blood type
Does the patient have current pregnancy complications or had a history of pregnancy complications? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____						
Physician managing the pregnancy and delivery				Phone		Fax
Address of planned location of delivery						



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Patient Name (last, first, initial)	Date of birth (yyyy-mm-dd)	PHN
TB Screening- Symptoms and History		
Check the appropriate boxes	No	Yes
Presence of cough lasting more than 2 weeks		
Weight loss, if yes specify _____ lbs. in _____ length of time		
Night sweats		
Fever		
Fatigue		
Haemoptysis (blood in sputum)		
Previous active TB and treatment		
Previous significant Mantoux or chest x-ray results		
Extensive travel (or birth) in a country with high incidence of TB		
Other risk factors (i.e. aboriginal, elderly, homeless, health care worker)		
Poor general health status and risk factors for progress of disease		
Further TB screening/assessment required- if yes, please send results		
Medical Approval		
In your opinion is this patient medically stable and appropriate for admission to Residential Addiction Treatment?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		
Physician's Name	Signature	Date (yyyy, mmm, dd)
Psychiatric Review/ History (send psychiatric evaluations and/or discharge summaries (if available))		
Addictions- note date of last use, pattern of abuse and severity of addiction (e.g. alcohol, cocaine, opioids, cannabis, gambling, tobacco, etc.)		
Primary	Secondary	Tertiary
Is there evidence of the following? (please include your judgement related to current severity of mental health concerns)		
	No	Yes
		Comments
Mental development and/or learning disorders? (e.g. depression, anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)		
Underlying pervasive or personality conditions		
Acute medical conditions and physical disorders aggravating mental health (e.g. brain injury, cognitive impairment, chronic pain, insomnia)		
Contributing psychosocial and environmental factors		
Global Assessment of Functioning		
Is there a history of self-harm, suicidal thoughts or suicide attempts? (If yes, pertinent psychiatric reports/assessments are required)		
Psychological Approval		
In your opinion is this patient medically stable and appropriate for admission to Residential Addiction Treatment?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		
Physician's Name	Signature	Date (yyyy-mm-dd)



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Patient Name (last, first, initial)			Date of birth (yyyy-mm-dd)			PHN		
At Poundmaker's Lodge Treatment Centres, we have a restricted medication list which indicates medications we do not allow the clients to enter treatment with. We ask the physician if there is an alternative medication the patient can be taking and if not; please include a note as to which medication the patient will be taking and why an alternative cannot be given.								
Medications (if more room is needed, attach list)								
Medication	Dose	Route	Frequency	Reason given	Start Date	End Date	Prescribed By	Phone Number

Please remind patient that in order to be admitted to Poundmaker's Lodge, they need to:

- Be well enough to participate in the program and remain alcohol and drug free for at least 72 hours prior to Admission.
- Ensure any new medications not listed above have been pre-approved by the Admissions department.
- If the patient's medical or psychological condition changes before their scheduled admission date they must contact the Admissions department.

Physician's Name		Signature		Date (yyyy-mm-dd)	
Mailing Address					
City/Town		Province	Postal Code	Phone	Fax
Primary Physician's Name (if different than above)				Phone	Fax
Other (e.g. psychiatrist or other specialist relevant to this admission)				Phone	Fax

Physician's Stamp



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What types of medications are restricted at Poundmaker's Lodge Treatment Centres?

The following medications are restricted:

Opioid Pain Medications <ul style="list-style-type: none"> • Codeine & Codeine containing products (e.g. Tylenol #3) • Morphine (eg. <i>Kadian</i>) • Fentanyl • Hydromorphone (<i>Dilaudid</i>) • Oxycodone (<i>Percocet, OxyNeo</i>) • Methadone (<i>Metadol, Methadose</i>) • Meperidine (<i>Demerol</i>) • Tapentadol (<i>Nucynta</i>) • Tramadol (<i>Zytram, Ralivia, Tridural</i>) • Pentazocine (<i>Talwin</i>) • Propoxyphene (<i>Darvon</i>) • Buprenorphine (<i>BuTrans, Suboxone</i>) 	Benzodiazepines <ul style="list-style-type: none"> • Alprazolam (<i>Xanax</i>) • Bromazepam (<i>Lectopam</i>) • Lorazepam (<i>Ativan</i>) • Oxazepam (<i>Serax</i>) • Temazepam (<i>Restoril</i>) • Triazolam (<i>Halcion</i>) • Chlordiazepoxide (<i>Librium</i>) • Clonazepam (<i>Rivotril</i>) • Clorazepate (<i>Tranxene</i>) • Diazepam (<i>Valium</i>) • Flurazepam (<i>Dalmane</i>) • Nitrazepam (<i>Mogadon</i>)
Psychostimulants <ul style="list-style-type: none"> • Dextroamphetamine (<i>Dexedrine</i>) • Amphetamine Mixed Salts (<i>Adderall XR</i>) • Lisdexamfetamine (<i>Vyvanse</i>) • Methylphenidate (<i>Ritalin, Biphentin, Concerta</i>) • Modafinil (<i>Alertec</i>) 	Miscellaneous <ul style="list-style-type: none"> • Varenicline (<i>Champix</i>) • Nabilone (<i>Cesamet</i>) • Dronabinol (<i>Marinol</i>) • Medical Marijuana • Zopiclone (<i>Imovane</i>)

(Note: This list is not exhaustive and other medications may be subject to restriction)

What if I am taking Methadone or Suboxone for opioid dependence treatment?

Methadone and suboxone will be accepted at Poundmaker's Lodge Treatment Centres only if your physician has indicated you are on a stable maintenance dose.