
# YOUTH REFERRAL APPLICATION PACKAGE

# Welcome to Wilp Si'Satxw Community Healing Centre

Together we can make a difference in delivering quality service to youth who are seeking help for their addictions and collateral issues.

## PHILOSOPHY

Wilp Si'Satxw believes that people who are addicted to spirit destroying chemicals can gain power over their addictions. It is with this belief that the primary purpose of Wilp Si'Satxw is to provide a holistic, spiritual-based Healing Centre where people can go through the processes that will start them on the road to recovery. This approach looks at the following realms within an individual as important to the healing journey.


Each person has the ability to confront problem issues and secure their personal power to walk in health and wellness. Each of you are responsible for yourselves and your self healing is a personal choice.

## OUR GOALS INCLUDE:

Providing information concerning:

1. Alcohol & drug abuse
2. Traditional native values
3. Communication
4. Spirituality
5. Alanon
6. Self care

# DIM SI LAX NOKHL K'UBA WILKSIHLXW

GITXSAN PRINCES AND PRINCESSES
WILL BE STRENGTHENED AND PURIFIED

## REFERRAL & ASSESSMENT PACKAGE

**REFERRAL WORKER:** _____

**ADDRESS:** _____

_____

**PHONE:** _____

**FAX:** _____

**INTAKE DATE:** _____

## CONFIDENTIAL

**CLIENT NAME:** _____

# CONTENTS



# WILP PARTICIPANTS PLEASE BRING:

- Comfortable clothing for: weather, sweats and exercise
- Personal hygiene items: shampoo, face soap, toothbrush, toothpaste, etc.,
- Sleeping bags, pillows, 3 towels
- Phone/calling cards
- Laundry items: laundry soap cubes, bounce
- Writing material: paper, stamps

## PERSONAL INFORMATION

Surname_____ Given Name_____ Age_____

Address_____ City_____ Postal Code_____

Phone_____ Birth Date _____Day _____Month _____Year

Sex: ○ Male ○ Female Care Card No._____

Band Name_____ Band Number_____

Living on Reserve ○ Yes ○ No If no, where were you raised?_____

Were you raised by Natural Parents? ○ Yes ○ No

If no, give details_____

Marital Status of Parents:

○ Single ○ Married ○ Common-law ○ Separated ○ Divorced ○ Widowed

Are you aware of your Native Culture? ○ Yes ○ No

If no, give details_____

Describe family situation. (Number of siblings; ages)

## I. MEDICAL/PSYCHOLOGICAL

Describe any special needs during program duration What problem(s) is motivating you to seek help?

What are the most important issues to be addressed within the Wilp Si'Satxw healing program?

What community support is available? (people or agencies)

## II. CLIENT HISTORY

Are there any alcohol and/or drug problems in your family of origin? ○ Yes ○ No

If yes, give details

Has there been a death in the family due to substance abuse? ○ Yes ○ No

What is your history and present use of alcohol and/or drugs? (Frequency of use, length of time using, attempts at stopping, etc.)

Describe behavior patterns requiring attention.

Significant past & present psychological issues relating to alcohol & drug

**LEGAL STATUS (PRESENT INVOLVEMENT):**

○ Not Applicable ○ Probation ○ Unlocking Aboriginal Justice ○ Other

Explain Situation:

Name and phone number of Probation Officer:

_____

**NOTE: COPIES OF ALL LEGAL DOCUMENTATION PERTAINING TO THE ABOVE MENTIONED MUST BE INCLUDED WITH REFERRAL PACKAGE.**

## III. SCHOOL HISTORY

7. What school are you attending?_____

8. What grade are you in?_____

9. How would you rate your school attendance? ○ Poor ○ Fair

10. Have you ever seen a school counselor? ○ Yes ○ No

11. Have you ever been on a School Contract as a result of poor behavior? ○ Yes ○ No
    If yes, explain

12. Have you ever been suspended as a result of using drugs or alcohol in school? ○ Yes ○ No
    If yes, explain

13. Please list any other significant events relating to school

14. Did your parents attend Residential School? ○ Yes ○ No

15. Did your grandparents attend Residential School? ○ Yes ○ No

## IV. CONSENT FOR TREATMENT

I, _____ (name of client),

agree to enter the Wilp Si'Satxw Community Healing Centre, P.O. Box 429, Kitwanga, B.C., V0J 2A0, for the purpose of treating my alcohol/drug dependency problem.

My reason(s) for applying for admission to the Wilp Si'Satxw Healing Centre is:

I would like to learn about:

For admission to the Wilp Si'Satxw Healing Centre, you must:

- be able to participate fully in the program
- complete all intake and medical forms
- abstain from the use of alcohol and non-prescribed drugs

I understand and agree to accept the conditions of this program as outlined.

Student/Client Signature_____

Parent/Guardian Signature_____

Date_____

## V. WAIVER

As the legal guardian for, _____,

I, _____, hereby agree to render and save harmless from all liability all staff, volunteers, and board members of the Wilp Si'Satxw Society for any accidental injuries and/or any losses of, or damage to, any personal property which may occur throughout the duration of his or her stay at the Wilp Si'Satxw Healing Centre.

Student/Client Signature_____

Parent/Guardian Signature_____

Date_____

## VI. PRE-ADMISSION MEDICAL EVALUATION

Client's Name:_____ Medical #_____

### CLIENT RELEASE

I, _____ , hereby request and permit my physician to release medical facts and assessment about me to _____ and Wilp Si'Satxw Society. The photocopy of my signature on this form is as valid as the original.

Client's Signature:_____ Parent/Guardian:_____

### TO THE PHYSICIAN

The above named client is to be medically assessed as a potential participant in our residential life-skills program. Our program is designed to help people who acknowledge that drinking or drug use has interfered with their effective functioning and who are physically and mentally ready to participate in a program of intense counseling activity.

### MEDICAL EXAMINATION

1. Date of last alcohol use_____
2. Date of last psychoactive drug use _____
3. Current Diagnosis_____

   Current Medication(s)_____
4. Medical problems to be followed while in treatment (MD is available for follow-up)

   _____
5. Any allergies? ○ Yes ○ No If so, what?_____
6. If female, date of L.M.P._____ Is patient pregnant? ○ Yes ○ No
7. Date of latest chest x-ray, if known, and result. (Please note, if last chest x-ray more than one year ago, it is mandatory for client to have had a chest x-ray before coming to treatment).
8. Functional inquiry - is there any disorder of the following?

| | | |
|---|---|---|
| Hair, skin, nails (especially current to recent infestations or infections) | ○ Yes | ○ No |
| Ear, nose, throat | ○ Yes | ○ No |
| Muscular-skeletal system | ○ Yes | ○ No |
| Blood, lymphatic system | ○ Yes | ○ No |
| Cardio-vascular system | ○ Yes | ○ No |
| Respiratory system | ○ Yes | ○ No |
| GI system | ○ Yes | ○ No |
| GU system | ○ Yes | ○ No |
| CNS - especially HX of seizures | ○ Yes | ○ No |
| Past history of TB | ○ Yes | ○ No |

9. Family History

| | | |
|---|---|---|
| Alcohol/drug problem | ○Yes | ○No |
| Psychiatric history | ○Yes | ○No |
| Adopted | ○Yes | ○No |

10. Physical Examination Height _____ Weight_____ BP/PR_____

| | NORMAL | ABNORMAL |
|---|---|---|
| Appearance | | |
| ENT | | |
| Hair, skin, nails | | |
| Muscular-skeletal system | | |
| Thyroid | | |
| Cardio-vascular system | | |
| Respiratory system | | |
| Abdomen | | |
| Central nervous system | | |
| Evidence of sexually transmitted disease | | |

11. Please comment on any abnormalities noted above.

_____

12. Have you any comments, suggestions or insights that might be helpful in terms of client's being physically and mentally able to participate in group, one-to-one counseling and living in residence for six weeks?

_____

**AS PER PRE-REQUISITE TO TREATMENT YOUR PATIENT MUST:**

1. Be free from all communicable diseases (i.e. STD, Scabies, lice) ○Yes ○No
2. Have a negative T.B. test in the last 6 months. Pos.○ Neg.○ Date_____
3. Be clean and sober from alcohol and all psychoactive medications/drugs *(all mood or mind altering substances)* for a minimum of 14 days ○Yes ○No

Date of last use (Alcohol)_____ (Drugs)_____

A copy of recent lab work, if available, would be appreciated e.g. CBC, liver functions, FBS etc.

I have examined this client and find him/her to be fit to attend treatment.

Physician's Signature_____

Address_____ Date_____

Phone_____ Fax No._____

NOTE: PLEASE PRINT CLEARLY

**WILP SI'SATXW COMMUNITY HEALING CENTRE**
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250 849 5211 | Fax: 250 849 5374
Toll free: 877 849 5211
info@wilpchc.ca

# HOUSE RULES CONTRACT

These guidelines are provided to create a healthy, safe, positive environment for your program. Please read them and be prepared to follow them for the welfare of all.

Failure to follow these guidelines may result in:

- loss of privileges (eg. phone privilege or Saturday pass)
- Written warnings
- Dismissal (severity of the incident may justify immediate dismissal)

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**ALL STAFF MEMBERS HAVE THE AUTHORITY TO ISSUE INCIDENT REPORTS AND TO DISMISS CLIENTS.**

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Please initial all section boxes to acknowledge you understand and will follow guidelines:

## ☐ ALCOHOL AND DRUGS

- The use or suspected use of alcohol or drugs throughout the program is grounds for discharge.
- Luggage will be inspected upon arrival. Clients may be subject to room checks during their stay. Incoming parcels will be examined with a Staff member present.
- All medication, prescription, and non-description drugs to be turned in upon arrival.

## ☐ HEALTH AND SAFETY

- Smoking is not allowed in the buildings.
- Food and drink must be kept in the Dining area only.
- Residents are required to keep themselves clean, regular bathing is required. Please do laundry after sessions and before 10 p.m. See housekeeper for soap and supplies before 5:45 p.m.
- Please remain in the bed that you are designated to.
- Bedrooms are not to be locked at any time. (Fire regulations).
- In case of FIRE ALARM quickly conduct yourself to the gathering point. (Do not take this lightly)
- Beds need to be made and rooms cleaned each morning. We also ask that you cooperate in doing your assigned daily chores.
- No horseplay.
- Hats, chewing gum, pop and other junk food are not allowed on the premises or on outings.
- All walkman's, radios, clock radios, and tape recorders, cassette tapes and C.D.'s and vehicle keys must be turned in upon arrival.

## TELEPHONE

There will be no outside contact during the first 10 days of the program, this enables the clients to develop a bond within the healing community. The exception to this rule is with regards to phone calls which begin on the first Saturday after intake, all mail and messages will be forwarded to clients beginning the first Monday after intake.

- On the first Saturday after Intake, clients will be able to make personal calls, after this a schedule will be set up into 2 groups with each on alternate days and half hour calls.
    - It is important to note, phone calls are a privilege and not a right.
    - Phone calls will be granted provided chores and other duties have been completed.
    - Phone calls will take place between 6:00 pm and 7:00 pm Sunday to Friday.
- Clients who have cell phones should ensure their provider has coverage in the area, those clients without cell phones will be able to use the Residential office phone with staff supervision.
- Mail and messages will be delivered by your Counselor.
- No calls may be made during session, evening included.
- Please make sure your calls are completed within your time slot, if not, your phone privileges could be withheld.

## WEEKENDS

- All residents are to remain on the grounds area unless on a pass. Clients must sign out when leaving the residence and sign back in when returning to the residence.
- Depending upon conduct and participation, a pass may be granted on the second Saturday from 9 a.m. to 9 p.m.
- All passes must be approved by a counselor before leaving the grounds. If there are changes to the pass destination, approval must be given ahead of time.
- After the second week visiting hours are from 1 - 5 p.m. on Saturdays only.
- Visiting is confined to the Dining/Lounge area only. (Not bedroom areas) Sexual contact in residence is prohibited.
- Visitors under the influence of, or suspected of being under the influence of alcohol or other drugs are prohibited.

## OFFICE

- To see counselor or Executive Assistant please use the front door. The administration building is off limits except for one-on-one session with your Counselor.
- OFFICE IN RESIDENCE IS STRICTLY OFF LIMITS (except to take medication with assistance of Attendant, or if you are dealing with a personal issue). The office phone is not to be used at all. Music is to be turned on by staff only.

## OTHER

- Please do not lie down on, or put feet up on chesterfields in the day lounge. Also, no food or drinks are allowed in this area.
- Physical or verbal abuse towards staff and other clients is unacceptable.
- Please refrain from the use of profanity or other inappropriate language.
- Sexual contact between clients, and between clients and staff is prohibited e.g.) Kissing, inappropriate hugging/touching.
- Residents are responsible for all personal belongings and effects. All valuables, Bus tickets, and money in excess of $20 will be put away for safe keeping. These items will be returned upon request. Wilp Si'Satxw accepts no responsibility or liability for personal belongings and effects of residents and Visitors.
- Outside footwear must be taken off and other footwear worn in all buildings.
- Caps are to be removed in all buildings, T-shirts, hats, or other items depicting alcohol or any inappropriate messages are not permitted. Dress conservatively with respect to others.
- There are security monitors located in the residence building and grounds for the safety of the Clients and staff.
- Non-prescription drugs will not be administered, due to the new policy in place at Wilp Si'Satxw. If non-prescription drugs are doctor recommended, it should be clearly marked on the containers.

I, _____ have read the house rules and agree to comply with them for the duration of my stay. I understand that these rules are set for my own well-being and safety. I realize that failing to comply with the house rules may interfere with the safety and well-being of others and I am subject to disciplinary action as a result.

Client's Signature: _____ Date: _____

Witnesses by: _____ Date: _____

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# METHODONE & SUBOXONE CONTRACT

Client Name: _____ Date: _____

Start Date on ☐ Suboxone or ☐ Methadone (select one) was on: _____

My current therapeutic dose is: _____and the most recent change was on this date: _____

This must meet the 2 months (Suboxone) and 4 months (Methadone) stabilization period prior to coming to Wilp Si' Satxw. This means the dosage will not have been changed and it will not be changed while at Wilp Si' Satxw.

Prescribing Physician: _____ Clinic Address: _____

Ph: _____ Fax: _____

Please send a faxed copy of the scripts to: 3 Rivers Pharmacy, Ph: (250) 842 6040, Fax: (250) 842 0154 and ensure the hard copy is brought to be dropped off upon client arrival when accepted into the program.

## Please initial all boxes to acknowledge you understand and will follow these guidelines:

☐ I agree that I will have 2 weeks of fully sobriety or more prior to coming.

☐ I agree that I will have been stabilized on suboxone or methadone prior to coming.

☐ I acknowledge that I will take medications at the given time by the nurse or designate.

☐ I acknowledge that there will be no changes to suboxone or methadone dosages. I agree to a random urine test if required by the nurse at Wilp Si' Satxw.

☐ I acknowledge that Wilp Si' Satxw is a rural treatment facility and I am medically stable prior to coming unless otherwise discussed with Wilp Si' Satxw.

☐ I agree to work with my physician to have the scripts filled for both your travel and stay at Wilp Si' Satxw prior to coming.

☐ I acknowledge that if I leave early that I will be given my travel carries only, the rest will be disposed of accordingly.

☐ I acknowledge that I have sent a faxed copy of my prescriptions to: 3 Rivers Pharmacy

☐ I acknowledge that if I do not follow with these guidelines that I may be sent home.

****NOTE: Max daily dose cannot exceed 20mg of Suboxone or 70mg of Methadone. Kaidian is not accepted at this time.****

Client's Signature: _____ Date: _____

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# CONSENT FOR TREATMENT

I, _____(name of client), agree to enter the Wilp Si'Satxw Society Community Healing Centre, P.O. Box 429, Kitwanga, B.C. V0J 2AO for the purpose of treating my alcohol/drug dependency problem.

I understand for the client and staff to work effectively, the treatment program will include:

- Counseling assessments
- Spiritual, physical and psychological development
- Group therapy sessions/talking circles
- Contact with referral sources
- Maintenance of confidential client records as stated in the Alcohol and drug Commission Act of British Columbia.
- I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.
- I understand that treatment is a continuum. Therefore, I agree to be involved with aftercare.
- I understand the explanation of the above points and the above-named agency's program and guidelines and I, there for consent to undergo treatment at Wilp Si'Satxw.

Comments: _____

_____

_____ _____

Client's Signature Date

_____ _____

Parent or Guardian Signature *(if applicable)* *Phone No.*

_____ Date: _____

Witnessed by *(this may be referring person or assessor)*

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# CONSENT FOR RELEASE OF INFORMATION

This section is to be filled out if referral is made and client information is required.

Client Name: _____

Date of Birth: Day _____ Month_____ Year_____

I, _____ *(client's name)*, hereby give my permission for Wilp Si'Satxw Society Community Healing Centre, P.O. Box 429, Kitwanga, BC V0J 2AO.

To contact *(name and address of agency providing information)*

Name: _____

Address: _____

For information to be released, limited to *(describe type(s)* of information to be released).

_____

_____

I understand that no other information will be released to any other persons without my written consent unless these persons have a court order or are concerned with my medical treatment in an emergency situation. I also understand that I can withdraw or amend my consent to the release/request of information at any time.

Start date of consent _____. End date of consent _____

In order for this release to be valid, it must be completed in its entirety.

Client's Signature: _____ Date: _____

Witnesses by: _____ Date: _____
*(this may be referring person or assessor)*

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# PROOF OF VACCINATION INFORMATION

**PROOF OF VACCINATION IS REQUIRED WITH YOUR COMPLETED APPLICATION**

If you do not have physical proof (card or other paper document) you may attach a digital copy of proof of Vaccine when submitting this application via email.

PLACE PHYSICAL PROOF OF VACCINE HERE

AND

SCAN WITH YOUR APPLICATION.