REFERRAL PROCESS

To the referral person – Thank you for your referral.

We appreciate your cooperation in expediting the referral and admissions process. If we can be of assistance, please call us at **Isuarsivik Treatment Centre** at **(866) 964-9994**, or correspond by e-mail at rgrey@isuarsivik.ca

As the referral person, you should follow these procedures when sending clients to our program.

1. Read the sections called *Admission Criteria* and *Paying for Treatment* to determine eligibility of the prospective client.

2. Fill out and return the forms in this package Isuarsivik Treatment Centre by fax at 819-964-2041. The application for admission is to be completed in the presence of the prospective client.

3. Ensure that the following Admission forms are submitted as part of the application. Use this list as a checklist –

    - Residential Treatment Evaluation
    - House Guidelines Agreement
    - Personal Information
    - Client History
    - Contact Assessment
    - Consent for Treatment
    - Pre-admission Medical Evaluation

4. Upon receipt of all the forms, the referring person and/or client will be notified of an admission date. No admission date will be considered until the WHOLE admission form has been completed.

5. Client's willingness to engage in the treatment process is very important, and is linked to the reasons why they have chosen to apply for treatment. We consider the following to be the WRONG reasons for applying for treatment, and urge you to explore these with your clients.

    - To get my children back, court orders, looking good for court, my wife/brother/father/mother/husband children/other family members want me to come.

6. If your client is on **probation**, it is imperative that the probation information be included in the appropriate spaces in the assessment package. Your client must also submit a copy of the parole, probation or temporary absence order. Our admission policy allows for one probation client per intake. Should this information be omitted from the referral package, it could result in your client being discharged from treatment.

7. Confirm that the client has comfort monies and that travel arrangements have been made (including return fare).
8. Discuss the *Admission Criteria* and *General Guidelines* with your client.
9. Discuss follow-up and after-care plans with your clients. During the latter part of the program, the client prepares a personal recovery plan and the counsellor writes a discharge summary. The recovery plan and the discharge summary are available with a signed release (see page 27 of this package).
10. Ensure your client has a valid medical care card in his/her possession
11. Ensure your client is aware of clothing and personal needs including items on the list below –

    Minimum 4 complete changes of clothing (laundry facilities are limited)

    - White soled/non-marking soled runners (for gym)
    - Slippers, pajamas, and a bathrobe for use going back and forth to the washrooms
    - Summer and winter clothes appropriate to the season for going on traditional excursions (camping clothing, raingear, rubber boots etc)
    - Indoor shoes
    - Toiletries (shampoo, toothpaste, razors, feminine needs, etc.),
    - Writing paper, envelopes, stamps,
    - **Calling cards**
    - Comfort/spending money for 40 days,
    - Arts and crafts projects, if on hand, and
    - Musical instruments (guitars, accordions, harmonicas etc) are allowed.

At least ten days prior to admission, confirm that all the forms are completed and mailed and that all financial arrangements are complete. This includes arrangements for all travel, comfort money, and any additional expenses.

Note that intake arrival time is **before 7 pm**.

In our work at Isuarsivik we feel it is extremely important to welcome program participants upon arrival. In our opening circle participants are able to introduce themselves and connect with group members. This helps them to start working openly and honestly.

Welcome to the Isuarsivik Treatment Centre. Together we can make a difference through shared commitment to deliver a high quality of service to clients who are seeking help for their addictions.

Overview of the Program

The Isuarsivik Treatment Centre is located in Kuujjuaq and offers a 42-day in-patient treatment program for alcohol and drug addictions. A Board of Directors consisting of seven members from various community services governs the Centre. The program commenced in February 1995.

VISION

Isuarsivik is a rich resource that promotes Inuit pride, self-empowerment, spirituality and healing through loving, healthy, protective lifestyles in safe, addiction free communities.

Mission Statement

To provide a culturally based wellness program, as a means for Inuit to achieve a healthy, addiction free lifestyle.

Philosophy

The foundation of our program is based on using traditional values in partnership with modern accepted treatment models reflecting mental, physical, spiritual and emotional well-being.

Treatment Program Specifics

The program consists of:

- Individual and group counseling sessions.
- Individualized treatment plans based on client goals.
- Education on addictions and related behaviors.
- Healing from unresolved trauma and grief.
- Spiritual and cultural Awareness.

Out of Respect for all belief systems, the spiritual component of the program will not interfere with, but enhance clients' present spiritual beliefs.

Program Resources

- Elders
- Alcohol and Drug Abuse Prevention Program
- Alcoholics Anonymous / Inuit Step Meetings
- Self-help support groups

The culturally-based 42 day treatment program assists the client in learning how to use Inuit culture, values and spirituality as major tools to maintain sobriety.

Application and Referral Process

- Self, Health and Social Services, Probation services, physicians etc., accepts applications.
- The complete application (including the consent and pre-admission medical exam and TB test or chest x-ray must be submitted and received prior to review of application.
- The Healing Centre reviews all documents.
- A letter confirming the acceptance or non-acceptance to the Treatment Cycle is sent directly to the individual.
- The client or the referring agent prior to admission must arrange travel arrangements, spending monies, and additional expenses.

Admission Criteria

1. Candidates of Inuit Ancestry over 18 years of age who can benefit from a treatment program based on Inuit culture, with a good knowledge of Inuktitut are invited to make application. For Inuit who do not have spoken Inuktitut, applications for specific English language programs are accepted.
2. Clients MUST abstain from ALCOHOL and/or MIND ALTERING DRUGS for a minimum of 72 hours prior to entering treatment. Longer is better. (This includes prescribed drugs such as Valium, Librium etc.)
3. Clients must be mentally and physically able to participate in a treatment experience
4. Clients must recognize that alcohol/drug abuse is a problem in their lives.
5. Clients must express a need and desire to change their present life-style.
6. Clients must have no outside interference during the six week treatment program such as court appearances, doctors, dentist or other medical appointments, child care concerns etc.

Additional Medical Criteria

1. Candidates must not require acute care or medically supervised detox services.
2. Clients must advise prior to admission if under Physician's care for co-existing medical and/or psychiatric conditions. Isuarsivik Treatment Centre will determine if candidate is suitable for treatment and advise client/referral worker accordingly.
3. If the client has a dual diagnosis, the referral worker must submit all documentation including those from a physician establishing that the client is stable and capable of participating in a treatment program. The referral worker must also provide the client's physician with the Isuarsivik Treatment Centre information to ensure that physicians are knowledgeable about the program prior to presenting their recommendation for treatment.
4. Clients may not be on psycho-active medication (and must present proof that these have been discontinues three weeks prior to admission).
5. All active diseases must be controlled.
6. If pregnant, the client must be in the second trimester. The first and third trimesters being higher health risk times for miscarriage or early birth.

Guidelines for Parolees or Probationers

- The Application for Treatment must be completed.
- A copy of the parole or probation order is included.
- Isuarsivik Treatment Centre accepts a maximum of two parolees or probationers per intake. Any applications over this number go on specific standby list for parole or probation.
- The client is expected to cooperatively participate and follow the treatment guidelines and the program with the understanding that the Treatment Centre is under no obligation to keep a client who does not participate.
- Isuarsivik Treatment Centre is not under any obligation to accept a person who has been legally ordered to attend the program.
  The Isuarsivik Healing Centre Policy is not to accept clients who are presently incarcerated.
- Probation officers shall be advised if a client does not attend treatment, or leaves the program before completion.

ISUARSIVIK

Application for Admission

NOTE:
Please make sure you answer ALL questions in this referral package to the best of your ability, and make sure you get the Medical Evaluation done before sending it back to us. PLEASE make sure the client gets the list of things he/she needs to bring. And give us the signed original package, as they are legally binding and we or the client might need them for legal purposes. Thank you!
(Referral is the Social Worker, Lawyer, or probation officer or whoever is sending a client for treatment. And Client or applicant is the person going for treatment)

Part 1: Information to be completed by applicant (please print)

First name: _____ Last name: _____

Date of Birth: Month:_____ Date: _____ Year:_____

Mailing address (client): _____

Community: _____Province: _____

Postal code: _____

Home Tel #: _____Work Tel #: _____

Marital Status: _____Number of children: ___ Ancestry: _____

Social Insurance Number: _____ Health Card Number: _____

Education: _____ Occupation: _____

Employer: _____

If not working, source of income to support yourself/family: _____

Next of kin to be notified in case of Emergency: _____

Telephone number: _____ Relationship to Applicant: _____

It is Isuarsivik's policy that any person who is admitted for treatment must be free of alcohol and all illicit substances for a period of 72 hours prior to admission.

I understand and agree to accept the Isuarsivik program as prescribed and adherence to all Isuarsivik house rules and regulations throughout my length of treatment.

Dated: ____ day of _____, 20____

_____ _____

Client's name (please print) **Signature**

_____ _____

Referral **Signature**

Information to be completed by referral (please print)

Name of Referral Agency: _____

Name of Referral: _____ Title: _____

Agency Telephone: _____ Fax: _____

Agency Address to send the Treatment summary to:

_____

_____

_____

1. Is the client seeing the referral regularly? Yes ___ No ___
2. If yes, how much contact in the past six months? _____
3. Will client continue working with referral person or agency for follow up after treatment? Yes___ No___

If not, who will the client be seeing to get more support after treatment:

Name_____ Title: _____

Telephone: _____ Fax: _____

PART 11: INFORMATION TO BE COMPLETED BY REFFERAL AND APPLICANT

Was client coerced (forced) (includes attendance required by law) into coming or did he/she decide voluntarily? Circle the ones that apply to you.

Parole	Probation	Court order	Choice of (going to jail or treatment)
Charges	Court cases	Outstanding warrants	Department of Youth Protection
Outstanding custody issues		Employment reasons	

Give details:

_____

_____

_____

Does the client have any prison convictions or criminal record? If yes, indicate reasons and outcomes: _____

_____

Probation/Parole officer's Name/Location/Phone and Fax No's

_____

Substance Abused (used)

Primary Drug of Choice _____ Last day of use: _____

Alcohol/Yrs _____ Hallucinogens/Yrs _____ Narcotics/Yrs_____

Prescription Drugs _____ Solvent/Inhalants_____ Other: _____

Secondary Drug of Choice: _____/Yrs Last day of use: _____

Does the client perceive himself/herself as having other addictive behaviors? If yes, please name: (Bingo, Card games, Casino, sex, food, work, shopping, relationships, Television, X-box games etc)

_____

Reaction to substance abuse – indicate all effects of experience.

Hangovers	Shakes	Seizures	DT's	Ulcers
Cirrhosis	Heart Problems	Blackouts	Vomiting	

Change of tolerance? _____

Behavioral changes/problems? _____

Were you thinking about drinking or using drugs all the time? Yes___ No ___

Did you use upon waking up? Yes ___ No ___

Have you ever tried to control your use of substances? Yes ___ No ___

Is someone else's alcohol or drug use negatively affecting your life? Yes ___ No ___

In what ways is this affecting you?

_____

_____

Relationship to you: _____ how long has it been going on?
_____**TWENTY QUESTIONS**

Are you an alcoholic? (Apply this for drug addiction also.)

To answer this question, ask yourself the following questions and answer them as honestly as you can.

1.	Do you lose time from work due to drinking?	___ Yes	No
2.	Is drinking making your life unhappy? _____	Yes	No
3.	Do you drink because you are shy with other people?	___ Yes	No
4.	Is drinking affecting your reputation? _____	Yes	No
5.	Have you ever felt remorse after drinking?	___ Yes	No
6.	Have you gotten into financial difficulties as a Result of drinking? _____	Yes	No
7.	Do you turn to different friends or go to different places when drinking? _____	Yes	No
8.	Does your drinking make you careless of your family's welfare?	___ Yes	No
9.	Has your ambition decreased since drinking?	___ Yes	No
10.	Do you crave a drink at a definite time daily?	___ Yes	No
11.	Do you want a drink the next morning?	___ Yes	No
12.	Does drinking cause you to have difficulty in sleeping?	___ Yes	No
13.	Are you more careless when drinking?	___ Yes	No
14.	Is drinking jeopardizing your job or business?	___ Yes	No
15.	Do you drink to escape from worries or trouble?	___ Yes	No
16.	Do you drink alone? _____	Yes	No
17.	Have you ever had a complete loss of memory as a result of drinking? _____	Yes	No
18.	Has your physician ever treated you for drinking?	___ Yes	No
19.	Do you drink to build up your self-confidence?	___ Yes	No
20.	Have you ever been to a hospital or institution on? account of drinking? _____	Yes	No

If you answered YES to any one of the questions, that is a definite warning that you may be an alcoholic. If you answered YES to any two, the chances are that you are an alcoholic. If you answered YES to three or more, you are definitely an alcoholic.

CLIENT HISTORY
Substance Abuse Profile

Substance(s) Abused	Pattern & Frequency of use in the past 6 months: Occasionally, Daily, Weekly, monthly, Binge. Or other.	Method of use: N-nasal/snort O-oral/swallow IV-inject IS-inhale/smoke	Average amount used in a 24 hour period	Length of time used: In months, years etc.	Date of last use: include time, date and year.
Beer					
Wine					
Hard Liquor					
Coolers					
Homebrew					
Marijuana/Cannabis					
Hashish/Hash oil					
LSD					
Ecstasy					
PCP					
MDA					
Mescaline					
Mushrooms					
Heroin					
Morphine					
Codeine					
Sleeping pills					
Tranquilizers					
Speed					
Cocaine					
Crack					
Methamphetamines					
Gasoline					
Glue					
Solvents					
Aerosols					
Listerine					

Part III: PRESENTING PROBLEM

1. What event(s) took place that caused the client to seek help at this time?

_____

_____

_____

CLIENT'S PERCEPTION OF PROBLEM

1. Does client feel he/she has an addiction problem? Yes ___ No ___

1.2 How does the client feel of his/her alcohol/and or drug use:

_____

_____

_____

2. Are others concerned about client's addiction? If yes, give client's perception:

_____

_____

_____

3. Does client express a need to change? Yes ___ No ___

_____

_____

_____

Medical/Psychological Factors/Mental Health Issues/Special needs

1. Significant past and present medical issues (i.e. cancer, diabetes, impairment – hearing loss, illiteracy, loss of limb):

_____

2. Significant past and present psychological issues.
Do you have a history of depression? ___ Yes ___No If yes, for how long? _____

3. Have you ever thought of suicide? ___Yes ___ No If yes, more than once? and when?

_____

_____

4. Details of client's history of involvement with the following:

Alcoholic Anonymous	When? _____	How long? _____
Narcotics Anonymous	When? _____	How long? _____
Psychologist	When? _____	How long? _____
Psychiatrist	When? _____	How long? _____
Counsellor/Friendship Centre	When? _____	How long? _____
Mental Health	When? _____	How long? _____
Treatment Centre	When? _____	How long? _____
Social Services	When? _____	How long? _____
Detox	When? _____	How long? _____
Other Support Groups	When? _____	How long? _____

Please give details of the outcome of the above involvement. _____

_____

_____

REFERRAL'S PERCEPTION OF THE CLIENT

1. How is the client's emotional state:

_____

_____

_____

2. How is the client's insight into presenting problem

_____

_____

_____

3. How is the level of client's motivation or denial:

_____

_____

_____

CLIENT RELEASE

I, _____ (Please print client's name), request and permit Isuarsivik to forward my discharge/treatment summary to:

Referral agency, title and name (i.e. social worker, intake office, probation officer):

_____

_____

_____

_____

Client's signature: _____Date: _____

RESIDENTIAL TREATMENT EVALUATION

If the client answers "No" to any of the questions – 1 through 5, he/she is not yet ready for intense treatment and the following recommendations should be taken into consideration:

Client should become involved in sober/clean social and recreational activities.
Refer client to AA meetings or another self-help group, where applicable.
Conduct a re-assessment of client's readiness for treatment again in three to six months.

1. Client expresses a need to change his life situation?..... Yes____
No____

2. Does client show willingness to make changes?.....Yes____ No____
   -For pre-treatment evaluation?..... Yes____ No____
   -For residential treatment?.....Yes____ No____
   -For after-care?..... Yes____ No____
   -For follow-up?.....Yes____ No____

3. Is client able to physically and mentally do daily living chores,
   Treatment and recreation activities?.....Yes____ No____

4. Is client able and willing to be involved in intensive group and
   Individual counseling activities?..... Yes____
   No____

5. Does client have post-treatment plans?
   -For basic needs? (e.g. housing, finance, etc.)..... Yes____ No____
   -For outpatient/self-help?.....Yes____ No____
   -To continue cultural/spiritual activities?..... Yes____ No____
   -Other (specify) _____

6. Does client have family/friends to support him/her being
   Clean/sober after treatment?.....Yes____ No____

7. When this client expresses anger clean/sober, is he/she
   harmful to self, others or property?..... Yes____ No____

8. Is the client aware that Isuarsivik is not willing to accommodate
   any personal obligations or appointments during the
   treatment cycle?..... Yes____ No____

House Rules
(Give a copy to applicant)

To all participants
The following will help you in contributing to a positive environment for your program and healing. Please read these guidelines carefully—and for the welfare of all the participants, be prepared to follow them.

1. Alcohol and Drugs Abstinence Requirement

Isuarsivik is alcohol and drug treatment center where as all participants are required to abstinence of using alcohol and or drugs while being resident of Isuarsivik. There is a **zero tolerance** to alcohol and or drug (mind altering drugs) use while being in Isuarsivik program. Participants using mind altering **will be discharged immediately from the program** including one's possession and offering and soliciting drugs to anyone.

2. Unacceptable Behavior

- Residents fighting or destroying property will be discharged from the program.
- Sexual relations between residents and staff and sexually harassment will not be tolerated.
- Verbally threats, physical violence, swearing at other residents and or staff will not be tolerated.

Dismissal from the results from above-mentioned unacceptable behavior will be immediately dealt with. There will be warnings but if there is no immediate change in behavior "instant" dismissal will occur.

INSTANT DISMISSAL CAN BE TAKEN ANY TIME DURING THE PROGRAM BY ISUARSIVIK MANAGEMENT TEAM.

3. BEHAVIOR GUIDELINES

a. You are to remain with the boundaries of Isuarsivik at all times, except when accompanied by staff or on pass.

b. Do not visit anyone else's bedroom without an invitation. Visiting and chatting takes place in the living room, outside deck and dining room, not in bedroom.

c. All valuables and monies in excess of $20.00 should be turned to the administration for safekeeping. They will be returned to you upon request. If you decide to keep all your money, you will sign an agreement that Isuarsivik is not responsible for any losses.

d. You are responsible for all your personal belongings and effects. Any items left behind when you leave will be disposed of (normally after 30 days). Isuarsivik accepts no liability or responsibility for the personal belongings and effects of residents or visitors.

e. Gambling is not allowed.

f. Running or soft-soled shoes are to be worn in the gymnasium and shoes must be worn all the time.

g. Appropriate clothing is mandatory and reflects respect—no halter tops, bare midriffs, muscle shorts, short shorts (inseam 3" above knees), see through or ripped clothing, logos promoting alcohol or drugs etc. Spandex shorts or pants must be worn with a long shirt. No sleepwear outside of your bedroom.

h. Absolutely NO videos are to be brought in from outside without approval by the Counselors.

4. TELEPHONE CALLS

a. You are permitted one phone call to your family the day you arrive, to let them know you have arrived safely. Phone calls are permitted every day for 15 minutes per client. Telephone schedule is from **6:00 pm to 10:00pm** (not during dinner) and **as soon as the chores are done during the week-ends. Those who do not go out on their day pass can have the phone from 9:00am to 9:00pm.**

b. Telephones are available for residents and again **phone calls are limited to 15 minutes** in order to provide for everyone have a chance to use telephone.

c. **Calling cards must be used for long distance calls.** Collect calls are not accepted from outside callers.

d. You will **not** be called out of session and any time of the day to answer the telephone. Staff will take messages and distribute them after program each day.

e. Staff will take only emergency phone calls in the evening, nights and on weekends. They are not authorized to acknowledge the presence or absence of any clients, and will not pass along messages

Note: telephone time schedules are subject to changes.

5. SCHEDULE

a. You are to be up by **7: 00am** in the morning during the week and by **8:30am** on the weekends.

b. **TV will be turned off by 10:30pm** and bedtime is **11:00pm** from Sundays to Thursdays.

c. On Fridays and Saturdays **TV will be turned off by 12:30am** and bedtime is **1:00am**.

d. You are accountable and responsible for attending **all** program sessions and AA meetings **on time**—on weekdays and weekends.

e. Residents out on a pass must return by **9:00pm**

6. Radios, TV, etc. are not to be turned on until **after 6:00pm,** or until all chores are completed. Volume to be moderate at all times. IPods or any personal music devices will be handed over to clients and can be used **only after 6:00 PM.** iPods and personal music devices are to be in administration safe from **10:00pm**.**HEALTHY AND SAFETY**

a. Smoking is not allowed in the building. Smoking is allowed outside at the back of the Centre. Ashtrays are supplied and it is expected that you will use them. Cigarette butts are not to be thrown on the ground. Smokers are responsible to keep ashtrays clean **(We strongly discourage pregnant women smoking).**
b. All medication will be turned over to the administration office upon entrance. Isuarsivik treatment staff will monitor the taking of the medication. Administration staff are not responsible for any medications or belongings.
c. Use the bed you are assigned to and no other. You are responsible for making your bed and cleaning your sleeping area and bathroom each morning. And you are expected to wash your bed sheets at least once a week.

d. You are assigned regular daily chores, which must be completed before supper.

e. There will be no horseplay, running, or swearing.

f. Due to high incidences of communicable diseases please do not share cigarettes, pop or anything that can pass along germs from your mouth.
g. Money and valuables can be safeguarded by handing them in to the administration office, the Executive Director will keep them in a safe place.
h. If we have concerns regarding client's health we may refer to our consulting physician or dietician.

7. CHORES

a. Participants are required to do their assigned chores every day. You are responsible for your assigned chores.

b. It is strongly recommended participants can help someone else if they complete their chores early.

c. It is everyone's responsibility to wash your own snack dishes after supper.

8. VISITORS

a. Visitors will be asked to show a staff member anything they are bringing to the Center for clients. Bags will be searched, and unauthorized items will be removed.

b. Visitors are allowed only in the designated visiting areas (living room, dining area and outside deck) and are prohibited from entering the bedroom area.

c. Visitors under influence of alcohol or drugs are prohibited.

d. Sexual relations between residents and visitors are prohibited.

e. You are responsible for your visitors and letting them know of the House Rules.

9. PASSES

a. Passes are not time off, they are part of the program, an opportunity to try out, explore, and experience healthier choices in the community. You can share your successes of your day pass when you get back to the Centre.

b. Passes are not automatic RIGHT. Passes are a PRIVILEDGE and will only be issued if you attend all sessions, do your chores on a timely basis, and demonstrate progress in your treatment.

c. All residents are required to remain on the grounds unless on pass or on an approved walk.

d. Your Program Counselor and Executive Director approves passes.

e. If you fail to return by the time designated on your pass, you will be held accountable and responsible.

f. We strongly recommend that you do not attend places that use and promote the use of drinking, drugs, or gambling.

10. TRANSPORTATION

a. Clients will be picked up at the airport and brought to the Centre by Tulattavik Patient Services.
b. If granted a weekend pass, you are welcome to stay at the Centre. However, you will be required to follow day pass regulations. If you decide to go out, you will be on your own, arrange for your own rides etc. Clients are urged to call the Centre if they feel they are in trouble, they will be picked up.
c. Special needs will be addressed by your counselor and your group.

GENERAL GUIDELINES FOR RESIDENTS

AGREEMENT

I understand the General Guideline and agree to follow them.

***Client's name:** (please print): _____

***Client's signature**: _____

Date: _____

PRE-ADMISSION MEDICAL EVALUATION

*Client's Name _____Medical Number _____

Date: Month_____, Day: _____, Year: _____

CLIENT RELEASE

I,_____ (name of client) hereby request and permit my physician to release medical facts and assessments about me to _____and **Isuarsivik**. The photocopy of my signature on this form is as valid as the original.

***Client's signature**:_____

TO THE PHYSICIAN or NURSE

The above named client is to be medically assessed as a potential participant in our six week addiction program. Our program is designed to help people who acknowledge that their 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. **Isuarsivik** requires a client to have had a complete physical examination prior to admission. In order for a client to be successful in our program, the client has to be free of any psycho active/mood altering drugs, painkillers, sleeping pills, or tranquilizers that are being used addictively for a period of three months prior to admission.

MANDATORY
MEDICAL EXAMINATION
IMPORTANT: TO BE DONE BY DOCTOR OR NURSE, NOT BY THE CLIENT

Name: _____

Date of last alcohol/drug use: _____

Date of last psycho active drug use: _____

Current Diagnosis: _____

Medical problems to be followed while in treatment (MD is available for follow-up)

_____

Does patient have any allergies? _____ If so, to what? _____

Is patient pregnant? _____

Past history of Tuberculosis (TB) **___Yes ___No**

Date of latest chest x-ray, if known and results: _____

Has the client the following symptoms?

- Unusual cough ___Yes __No
- Sputum production ___ Yes __No
- Unexplained fever ___ Yes __No
- Night sweats ___ Yes __No
- Recent weight loss ___ Yes __No

If any of combination of these symptoms is compatible with active tuberculosis it is mandatory for client to have a chest x-ray before coming to treatment.

(Revised by Nunavik Regional Health Board Public Health department: March 2010)

Functional inquiry – is there any disorder of the following?

Hair, skin, nails (especially current or 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 hex of seizures	___ Yes	___ No
Past history of TB	___ Yes	___ No

Family History

Alcohol/drug problem	___ Yes	___ No
Psychiatric history	___ Yes	___ No
Adopted	___ Yes	___ No

Physical Examination

Height _____ Weight _____ BP/PR _____

	Normal	Abnormal
Appearance	___	___
ENT	___	___
Hair, skin, nails	___	___
Reticuloendothelial system	___	___
Muscular-skeletal system	___	___
Thyroid	___	___
Cardio-vascular system	___	___
Respiratory system	___	___
Abdomen	___	___
Central nervous system	___	___
Evidence of sexually transmitted disease	___	___

Please comment on any abnormalities noted above.

_____

_____

Present Medications:

_____

_____

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?

_____

_____

Clients attending treatment should be as free as possible from all drug abuse and should not be on any sedative-hypnotics. The client is not in need of acute hospital care; diseases are to be under control as much as possible – ESPECIALLY contagious diseases.
Clients should be checked for STDs before entering treatment.

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

Physician or Nurse's Signature and stamp_____

Date _____

Address _____

_____

Telephone _____