Sunshine Coast Health Centre

Admission Package

Occupational Trauma

(Client)

Client Admission Form

This is an interactive document. Simply place your cursor over the item you wish to fill in and begin typing.

Please complete, print this document and fax to 1-888-875-0511. A staff member will contact you within 24 hours.

Client (Patient) Information:

Name
(First) (Middle Initial) (Last)

Address
Street/PO Box

City/Town

Prov/State Postal/Zip

Telephone Numbers
Home: Cell:

Other (specify):

Email address:

Age Date of Birth

Provincial Health Care No.

Extended Health Care No.

Extended Health Carrier

Group Plan No. (Back of Card)

Requested Admission Date:

Funding Guarantor (if different from client):

Name
(First) (Last)

Address
Street/PO Box

City/Town

Prov/State Postal/Zip

Telephone Numbers
Home: Work:

Relationship to client? self-pay EAP employer family member other

Payment

How will you be paying? cheque money order wire transfer credit card

Source of Information (if different from Client or Funding Guarantor):

Name of person completing this application:
(First) (Last)

Relationship to Client

Telephone Numbers
Home: Work:

Cell:

Continued on next page

Client Admission Form p2

Sunshine Coast Health Centre

Referring Professional (if applicable):

Were you referred to Sunshine Coast Health Centre by one of the following professionals?

Therapist
Psychologist
Psychiatrist
Interventionist
Other: ____________________

Name of Professional(s):

1. Precipitating Event/Motivation:

Has a specific event(s) prompted this application?
Yes No

If yes, please describe:

2. Medical History (Biomedical Complications)

Primary Physician

City/Town

Prov/State

Office Telephone Number

Have you had any medical conditions/illnesses within the past two years? Yes No

If yes, please identify.

Are you taking any prescribed medications?
Yes No

Are you taking any over-the-counter drugs?
Yes No

If yes to either question, please provide name, dosage, duration of use, and reason taken.

Have you been hospitalized in the past year?
Yes No

Have you ever attempted suicide?
Yes No

If yes to either question, please describe and provide date(s).

Continued on next page

Client Admission Form p2

Sunshine Coast Health Centre

Please identify any known allergies.

Do you snore or have problems sleeping?
Yes No

Are you able to walk, feed, dress and care for yourself independently? Yes No

3. Psychological History (Emotional/Behavioral)

Are you **currently** seeing a psychiatrist?
Yes No

Name of psychiatrist?

Are you **currently** seeing:

Pyschologist? Yes No

Counsellor? Yes No

Name of Professional(s):

City/Town Prov/State

Office Telephone Number

Have you had any psychological/emotional problems in the **past two years?** Yes No

If yes, please describe:

4. Alcohol/Drug History

Complete for alcohol or any other addictive substances you have used (including nicotine) in the **past 6 months**.

Name of Drug

Pattern of use (daily, weekend, binge)

Amount used per occasion

Length of use

Date of last use

Name of Drug

Pattern of use

Amount used per occasion

Length of use

Date of last use

Name of Drug

Pattern of use

Amount used per occasion

Length of use

Date of last use

Name of Drug

Pattern of use

Amount used per occasion

Length of use

Date of last use

5. Treatment History

Have you previously been to treatment?
Yes No

If "Yes," please detail the history. If you require more space, please insert extra page(s).

Continued on next page

Client Admission Form p3

Sunshine Coast Health Centre

Name of Program

Where located

When

Outpatient or residential?

Was Program Twelve-Step based? Yes No

Did you complete the program? Yes No

If "No," how come?

Outcome (length of abstinence)

Name of Program

Where located

When

Outpatient or residential?

Was Program Twelve-Step based? Yes No

Did you complete the program? Yes No

If "No," how come?

Outcome (length of abstinence)

Name of Program

Where located

When

Outpatient or residential?

Was Program Twelve-Step based? Yes No

Did you complete the program? Yes No

If "No," how come?

Outcome (length of abstinence)

6. Family

Current marital status? Single Married Divorced Separated Widowed

Ages of children (if any)?

Is there a family history of alcohol/drug use or dependence? Yes No

If yes, please describe:

Family Program Participation

Do you have any family members interested in participating in the Family Program? Yes No

If so, please detail:

Continued on next page

Client Admission Form p4

Sunshine Coast Health Centre

7. Employment Status

Current employment status
- Employed
- Unemployed
- Length of current status

If employed, please describe nature of job:

Please describe impact of alcohol/drug use on employment history:

8. Legal History

Have you ever been charged or convicted with a Criminal Code offence*?
Yes No

**Note: for American applicants, Criminal Code offences refer to misdemeanor or felony convictions.*

If yes, please describe (include DUIs):

If yes, do you have any pending hearings?
Yes No

If yes, when?

9. Nutrition

Do you have any special dietary concerns?
Yes No

If yes, please describe.

10. Recovery

Please identify any strengths or resources for recovery, e.g., family support, employer support, personally motivated, etc:

Please identify any current obstacles to treatment or recovery:

Thank you. If you have any questions regarding this application or prefer to complete the questionnaire over the phone, please contact us toll-free at 1-866-487-9010.

For Office Use Only
☐ RP ☐ I ☐ GAW ☐ Y ☐ WM ☐ A ☐ O

Please complete the Consent to Release Medical Information form on page 7 before submitting.

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: ______________________________

Date of Birth: ______________________________

Personal Health Number (PHN): ______________________________

Primary Physician's Name: ______________________________

Phone: ______________________________

Fax: ______________________________

Dear Dr. ______________________________ ,

I, ______________________________, consent to release the following medical records for the last two years to Dr. Jacques du Toit, and to Dr. Stuart Howard of Sunshine Coast Health Centre:

Any and all types of records you have

Doctor visit notes

Lab reports

Emergency room notes

Clinical notes

Doctors orders

History & Physical

Specialist Consultations

Radiology Reports

Other: ________________

Please fax records to:

Attention: Sunshine Coast Health Centre Nursing Department

Fax: 1.604.487.9044

Phone: 1.866.487.9050 ext. 202

Client Signature: ______________________________

Date: ______________________________

Witness: ______________________________

Date: ______________________________

SUBMIT

I have read and agree to these terms.

Initial: Date:

PRE-ADMISSION CHECKLIST

THINGS TO BRING

- ❑ Provincial health care card
- ❑ Drivers license (if Canadian resident) or passport (non-resident of Canada) for boarding flights.
- ❑ Travel insurance for coverage of emergency medical services while in British Columbia (Highly recommended for non-residents of Canada and medically uninsured Canadians*)
- ❑ Money (cash, credit, debit, etc) for miscellaneous personal expenses
- ❑ Current Medications (only 3-4 days worth)**
- ❑ Toiletries (toothbrush, shampoo, shaving cream, etc.)
- ❑ Sleepwear (slippers, t-shirt and shorts or pajamas)
- ❑ Comfortable clothing sufficient for 7 days
- ❑ Weather-appropriate clothing and recreation wear (i.e. rain wear and hiking boots/outdoor shoes)
- ❑ Fitness wear (t-shirts, shorts, track pants, running shoes) for use in the fitness centre
- ❑ Swimwear (not cut-offs) and beach towel
- ❑ Musical instruments for leisure time (limited selection available onsite)

THINGS NOT TO BRING

- ❑ Clothing that promotes alcohol or drug use (Including names of bars or taverns), sexism, racism, or homophobia
- ❑ Drug paraphernalia
- ❑ Heating pad or electric blankets
- ❑ Weapons (including pocket knives)
- ❑ Valuable jewelry or expensive clothing
- ❑ Pornography
- ❑ Mouthwash or other toiletries containing alcohol
- ❑ Over-the-counter medications and herbal remedies****
- ❑ Nutritional supplements****
- ❑ Cannabis or THC-containing products (CBD products must be sealed and show the certified distributor and prescribing physician).

If you are not sure about a drug, supplement, beverage, or food item please check with Admissions prior to your admission date. Nutritional Supplements are available to clients via individual requests.

MISCELLANEOUS

Personal Electronic Devices: Personal communication*** (cellphones, smartphones, tablets, etc.), audio (iPods, MP3 players, etc.), and computing devices (e.g. laptops) are permitted provided that usage rules are observed at all times.†

Laundry Facilities: Complementary washing machines, dryers, irons, ironing boards and laundry soap are available on-site.

Visitors: Family members are welcome to visit Sundays and holidays from 12:00 to 5:00 PM.

Telephone: Clients can be reached on the client phone. Clients are responsible for providing this phone number to family and friends.

Luggage: Please note that Pacific Coastal Airlines charges extra for luggage weight exceeding 50 lbs. See their website for more details.

** Travel insurance does not cover expenses associated with non-emergency situations such as medical appointments or medications of any kind.*

***Changes to personal prescriptions may occur. All prescriptions are re-done by SCHC's pharmacist while clients are at SCHC. Any outside prescription medications will be stored and returned to clients upon discharge.*

**** Personal communication devices (e.g. smartphones) with cameras are permitted onsite as long as clients respect anonymity and refrain from taking photos of other clients.*

***** Items in this category will be confiscated and returned at time of discharge. Mood-altering drugs or medication deemed counter-therapeutic will not be returned.*

† Wireless internet is available for light bandwidth activities. Internet service is intended for communication purposes, not entertainment.

Mailing Address for Letters and Packages: Client's Name c/o Sunshine Coast Health Centre, 2174 Fleury Road, Powell River, BC, Canada V8A 0H8

I have read and agree to these terms.	
Initial:	Date: