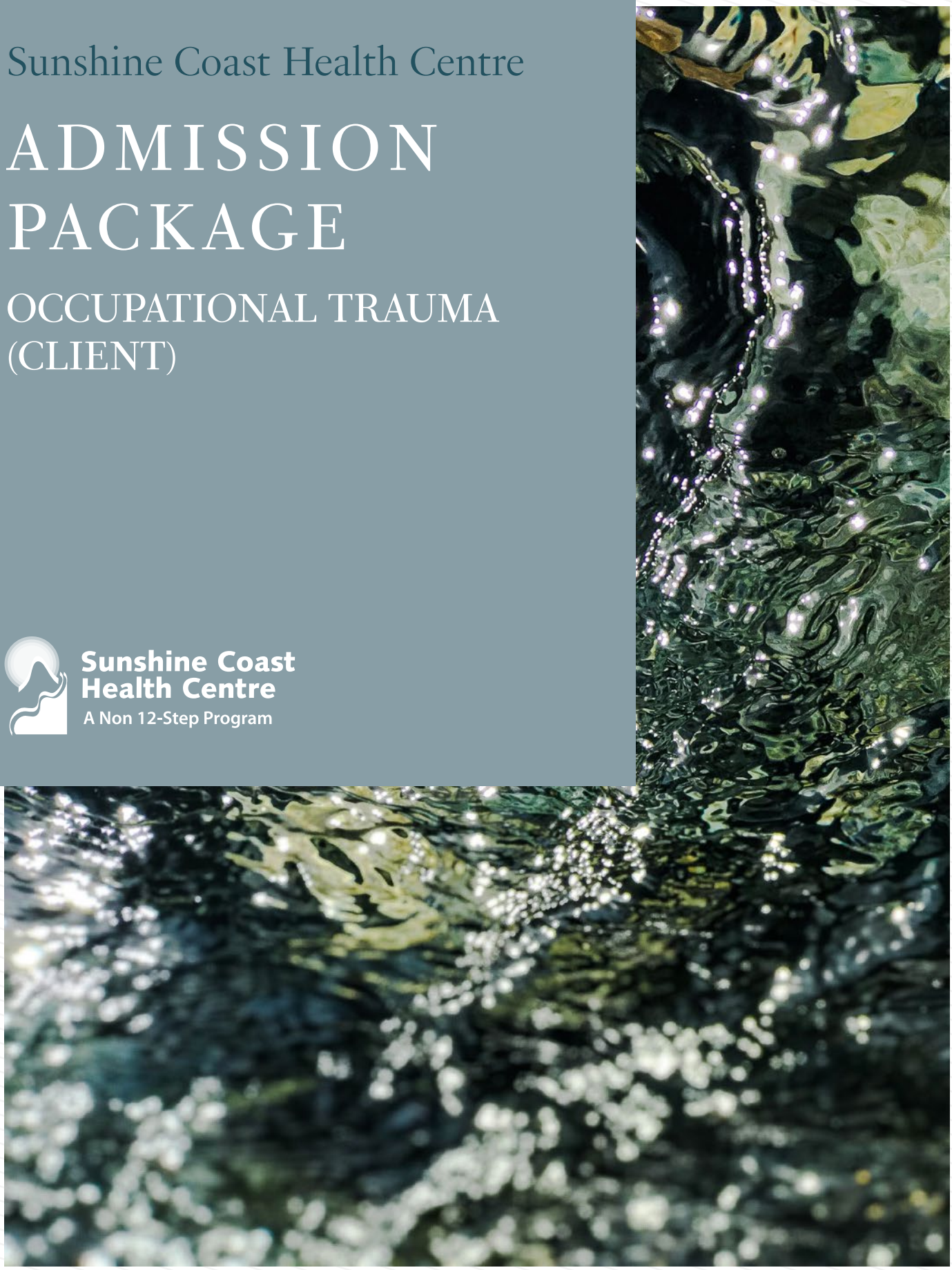
Sunshine Coast Health Centre

ADMISSION PACKAGE

OCCUPATIONAL TRAUMA (CLIENT)



Sunshine Coast Health Centre
A Non 12-Step Program

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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

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

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

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

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 ◯ Common Law

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

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:

What are your top three goals (objectives) for coming to SCHC?

What is your understanding of your addiction? Why do you think you engaged in your addiction?

What is your understanding of your current struggles and challenges in life?

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

SUBMIT

Sunshine Coast Health Centre
A Non 12-Step Program

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)**
- ❑ Medical Supplies (e.g. Diabetes testing strips)
- ❑ 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****

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:**