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**NNADAP/YSAC Family Intake & Referral Application**

**Child / Dependent (Substance Use & Legal History)**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| **A. Client Information**  |
| Surname:  | First Name: |
| Nickname or other name known by: | Date of Birth: |
| Health Card Number:  | Health Card Expiry Date:  | Age:  | Sex:* Female
* Male
 |
| Gender:* Gender Fluid
* No category describes me
* Unknown
* Decline to State
* Female/Woman
* Male/Man
* Transgender
* Intersex
* Two-Spirited
* English
* French
 | Client Address: | Client Phone: |
| Language Spoken:  | Language Preferred:  | Language Understood: |
| Nation Status: * First Nation Non-Status
* First Nation Status
* Inuit Non-Status
* Recognized Inuit
* Métis
* Client Not Eligible for Status
 | Treaty Number: |
| Band Name: |
| Other Indigenous Status:  | Relationship Status:  |
| Emergency Contact Name:  | Emergency Contact Relationship: |
| Emergency Contact Phone Number: | Next of Kin: |
| Relationship to Next of Kin:* Less than grade 8
* Completed high school
* Not completed high school
* Completed post-secondary
* Some post-secondary
 | Next of Kin Phone Number: |
| Education:  |  Literacy Level:* Illiterate
* Literate
* Needs assistance
 |
| Living Situation:* Homeless
* Group Home
* Shelter
* Foster Care
* Common Law
* Friend
* Unknown
* On-reserve
* Off-reserve
* Urban
* Rural
* Immediate Family
* Extended Family
* Lives Alone
 |
| Custody Information:* Orders of Supervision
* Unsupervised Visitation
* Continued Supervision
* Temporary Supervision
* Voluntary Placement Agreement
* Continuous Care (Ongoing Family Services)
* Customary Traditional
* Adoption
* Biological
* Kinship/Foster
* Recent Apprehension
* Voluntary Family Services
 |
| Social Worker Name and Contact Information:  |
|  |
| **B. Education and Social Status** |
| Grade Level | Has an Individual Education Plan | Has an Academic Assessment | Has Received Guidance Counselling | Has been previously apprehended | Has received a Behaviour Assessment |
|  | * Yes
* No
* Unknown
 | * Yes
* No
* Unknown
 | * Yes
* No
* Unknown
 | * Yes
* No
* Unknown
 | * Yes
* No
* Unknown
 |
|  |
| **C. Legal Status*** Unknown
* Yes
 |
| *Has your client ever been in trouble with the law?** No

***If yes, please explain:**** Criminal Court
* Family Court
* Drug Court Treatment
* Probation
* Charges Pending
* Court Referral
* Court Order
* Restorative Justice
* No Involvement
* Unknown
 |
| *Is your client under any of**these legal involvements?*  | *Is the client under any of the following legal conditions?** Bail
* Parole
* Temporary Absence Order
* No Involvement
* Other
* Unknown

**If other, please specify:** |
| *Gang Involvement:** Unknown
* Yes
* No

 |
| *Was alcohol or any other substances, such as ‘sniff’ or other drugs involved in your client’s legal dealing?***If other, please specify:** * Yes
* No
* Other
* Unknown
 |
| *Is your client seeking treatment as a result of a court order or family service order?***If yes, please explain:** * Yes
* No
* Unknown
 |
|  |
| **D. Chemical Use History - *Substance misuse prior to treatment history:***  |
| *At what age did your client start sniffing?*  | *At what age did your client start drinking?* |
| *At what age did your client start using other drugs?* |
| *Has anyone in their family or community received treatment for solvent/substance abuse?** Yes
* No
* Unknown

**If yes, please explain:** |
| *Has your client participated in a non-residential/community-based substance abuse program?** Yes
* No
* Unknown

**If yes, please explain:** |
| *Has your client received prior treatment at a residential addiction centre?** Yes
* No
* Unknown

**If yes, please explain:** |
| **Treatment Location** | **Treatment Date** | **Describe** |
|  |  | *(Completed/Not Completed?)* |
| Has your client used substances for the last year?YesNo Unknown**If yes, complete a DUSI-R Assessment.** |
|  |
| **E. Withdrawal Symptoms** |
| *Has your client experienced any of the following symptoms while withdrawing from substances in the last* *6 months?* |
| Symptoms | Describe |
| *Blackouts** Yes
* No
* Unknown
 |  |
| *Hallucinations** Yes
* No
* Unknown
 |  |
| *Nausea/Vomiting** Yes
* No
* Unknown
 |  |
| *Seizures** Yes
* No
* Unknown
 |  |
| *Shakes** Yes
* No
* Unknown
 |  |
| *Delirium Tremens (DTs)** Yes
* No
* Unknown
 |  |
| *Ever experienced DTs?** Yes
* No
* Unknown
 |  |
|  |
| **F. Mental Health History** |
| *Provide the following information about the client’s mental health status:* |
| Mental Illness | Describe  |
| *Been diagnosed with a mental illness** Yes
* No
* Unknown
 |  |
| *Currently being treated** Yes
* No
* Unknown
 |  |
| *Currently on psychiatric medication** Yes
* No
* Unknown
 |  |
| *Taking medication consistently** Yes
* No
* Unknown
 |  |
| *Eating (obesity, anorexia, bulimia, etc.)** Yes
* No
* Unknown
 |  |
| *Sex (promiscuity, etc.)** Yes
* No
* Unknown
 |  |
| *Internet / Texting** Yes
* No
* Unknown
 |  |
| *Gaming (video games and APP games)** Yes
* No
* Unknown
 |  |
| *Had your client ever spoken or written about killing themself?** Yes
* No
* Unknown
 |  |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:**** Yes
* No
* Unknown
 |  |
| *Hospitalized for suicide attempts?* ***If yes, when?**** Yes
* No
* Unknown
 |  |
| *Currently suicidal?** Yes
* No
* Unknown
 |  |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:**** Yes
* No
* Unknown
 |  |
| ***Treatment Location: Treatment Date:*** | **Describe:** |
| *If any treatment program was NOT completed, please provide details:* |  |
|  |
| **G. Social Functioning** |
| *Is there any known history of sexual abuse?* | * Yes
* No
* Unknown
 |
| *Is there any known history of physical abuse?* | * Yes
* No
* Unknown
 |
| *Is there any history of family violence that the client may have been witness to?* | * Yes
* No
* Unknown
 |
| *Any self-harming behaviour(s)?* | * Yes
* No
* Unknown
 |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: |
| * Sexually aggressive behaviors or promiscuity (verbal or physical)
* Uncontrollable outburst of anger
* Suicidal ideation
* Self-harm or mutilation
* Physical aggressive, abusive, or threatening behaviors
* Verbally aggressive abusive, or threatening behaviors
* Depression
* Suicidal attempts

***Please specify details and dates:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| * Recklessness/unhealthy risk taking
* Co-dependent/controlling
* ADHD (Attention Deficit Hyperactivity Disorder)
* Running away
* Severe and debilitating anxiety
* Eating disorder

***Please specify details and dates:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| * Mental Disorder
* Difficulty following rules or regulations
* Substance withdrawal (detoxification)
* Other destructive behaviours (i.e., vandalism, arson)
* FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects)
* Intellectual Development Disability
* Dislike of or disregard for the authority figures
* Medical complications that may affect treatment
 |
| *Does your client go to school?** Yes
* No
* Unknown
 | *Child Welfare Involvement?** Yes
* No
* Unknown
 |
|  |
| **H. Historical Trauma Event** |
| *Has your client experienced historical trauma?* | * Yes
* No
* Unknown
 |
| *What kind of historical trauma has your client experienced?** Attended residential school
* Experienced trauma in residential school
* Experienced physical abuse (not residential school)
* Experienced emotional abuse (not residential school)
* Experienced sexual abuse (not residential school)
* Experienced multiple foster care placements
* Experienced trauma in foster care
* Was separated from parents/family for other reasons
* A family member/friend attempted suicide in the past year
* Experienced natural death of a family/friend in the past year
* Experienced death of a family member/friend in the past year
* Experienced multiple deaths in my community in the past year
* Experienced disaster/crisis in my community in the past year
* Parent(s) attended residential school
* Grandparent(s) attended residential school
* Child abuse
* Intergenerational trauma
* Relocation
* PTSD
* Sixties Scoop Survivor
* Foster Placement
* Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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