North Bay Regional Health Centre

Nipissing Detoxification and Substance Abuse Programs
Application for Agency Admission

FOR STAFF USE ONLY **J** number _____ **Agency NA** _____

Admission Date: _____ **Admission Time:** _____

Residential Treatment Services **(RTS)**	Community Treatment Services **(CTS)**
❑ Residential Program	❑ Assessment ❑ Day Program

PLEASE COMPLETE FULLY TO AVOID DELAYS

TREATMENT REQUESTED (please check one) ❑ Residential Treatment Service
❑ Community Day Program Treatment Service

REFERRAL DATE: _____

PERSONAL INFORMATION:

Name _____
(surname) (full given name) (middle name)

Date of Birth (d/m/y): _____ Age: _____ Gender: ❑ M ❑ F

Maiden or Other Name _____ Mother's First Name:_____

Address: _____
(apt no. and street) (PO Box) (city) (postal code)

Home Number (home) _____ Other phone: _____

HEALTH CARD NUMBER: _____ Version Code: _____

Expiry Date if non Ontario HC: _____

MARITAL STATUS: ❑ Single ❑ Common law ❑ Married ❑ Separated ❑ Divorced ❑ Widow

PREFERRED LANGUAGE: ❑ English ❑ French ❑ Other: _____

RELIGION: Would you like to indicate your religion for your hospital record? ❑ No ❑ Yes

DATA COLLECTION: "We have 2 questions that are being asked for data collection purposes only."
1. If you had a choice would you prefer to receive services in ❑ English ❑ French ❑ Unknown
2. What is your primary language? ❑ English ❑ French ❑ Unknown ❑ Other: _____
("Unknown" response is only to be used if the patient is not able to answer i.e. unconscious).

NEXT OF KIN:
Name: _____ Relationship: _____

Address same as patient: ❑ No ❑ Yes

If no, address_____
(apt.) (street) (city/province) (postal code)

Home Phone Number: _____ Other Phone: _____

PERSON TO NOTIFY: Same as next of kin: ❑ No ❑ Yes
If no, Name: _____ Relationship: _____

Address same as patient: ❑ No ❑ Yes

If no, address_____
(apt.) (street) (city/province) (postal code)

Home Phone Number: _____ Other Phone: _____

REFERRAL SOURCE: ❑ Self ❑ Agency
Referent's Name: _____

Agency: _____

Address: _____
(suite) (street) (city) (postal code)

Phone: _____ Fax: _____

PHYSICIAN: _____ Phone No.: _____

Address _____
(suite) (street) (city) (postal code)

PHARMACY _____ Phone _____

Address _____
(suite) (street) (city) (postal code)

Method of payment for prescribed medications:
❑ Cash ❑ Private Drug Benefit Plan ❑ Ontario Drug Benefit ❑ Ontario Disability ❑ Other? _____

SEEKING TREATMENT FOR / CLIENT TYPE OF PROBLEM / REASON FOR VISIT:

❑ Alcohol Only ❑ Drug only

01 – Alcohol and/or Drug
02 – Alcohol/Drug/Gambling
03 – Gambling
04 – Family: Alcohol/Drug
05 – Family: Alcohol/Drug/Gambling
06 – Family: Gambling
07 – Other/Non Ontario Substance *(i.e. Crisis for accommodation)*

Date of last drink: _____ Date of last drug: _____

Please list names of drug use: _____ _____ _____

_____ _____ _____

FIRST TIME PATIENT AT NDSAP: ❑ No ❑ Yes

PREVIOUS TREATMENT TO THIS FACILITY: ❑ No ❑ Yes

If yes, please circle appropriate code:

02 - Less than a year ago
03 - One to two years ago
04 – Two to four years ago
05 – Four years ago or more
06 – Treatment at other center
88 – Unknown

TREATMENT MANDATED/REQUIRED BY: _____

01 - None
02 - Treatment or jail choice
03 - Probation/Parole condition
04 - Child Welfare Authority
05 - Condition of employment
06 – Condition of school
07 - Condition of family
08 - Other
88 – Unknown

LEGAL STATUS: Please circle appropriate code

01 – No Problems
02 – Awaiting Trial/Sentencing
03 – Probation
04 – Parole
05 – Incarcerated
06 – Other, _____
88 - Unknown

Do you have any court dates to attend: ❑ No ❑ Yes

If yes, indicate dates: _____

Are you currently on: : ❑ probation ❑ on bail ❑ house arrest ❑ parole ❑ incarcerated ❑ NA

YOUNG OFFENDER: : ❑ No ❑ Yes

EDUCATION:

01 – No Formal Schooling
02 – Some Primary Schooling
03 – Primary School
04 – Some High School
05 – Completed High School
06 – Some College/CEGEP/Tech
07 – Complete College/Nurse
08 – Some University (Not complete)
09 – University Degree
88 - Unknown

ETHNICITY IDENTITY: _____ (predominant ethnic identity)

01 – Canadian
02 – Aboriginal – Status
03 - French
04 - English
05 – German
06 – Scottish
07 - Irish
08 – Italian
17 - Metis
33- Other _____ (specify)
34 – Aboriginal – Non Status
88 – Unknown/Refused

EMPLOYMENT STATUS: _____

01 – Employed Full-Time (Self-employed)	04 – Student/Training	07 – Retired
02 – Employed Part-Time	05 – Disabled (Not Working)	88 – Unknown
03 – Unemployed (Looking)	06 – Not in Labour Force	

INCOME SOURCE: _____

01 – Employment	05 – Other Insurance – Not EI	09 – None
02 – Employment Insurance	06 – Ontario Works	10 – Family Support
03 – ODSP: Ontario Disability	07 – Retirement Income	88 – Unknown
04 – Disability Insurance	08 – Other	

NON MEDICAL INTRAVENOUS DRUG USE: _____

01 – Never Injected
02 – Injected Prior to 1 Year
03 – Injected in Last 12 Months
88 – Unknown

METHADONE / SUBOXONE:

Are your currently prescribed: **Methadone** ❑ Yes ❑ No **Suboxone** ❑ Yes ❑ No

PRESENTING PROBLEM SUBSTANCES:

Please indicate frequency of use in **last 30 days** by selecting code number.

Problem Substance #1 _____ Sub 1 Frequency _____
Problem Substance #2 _____ Sub 2 Frequency _____
Problem Substance #3 _____ Sub 3 Frequency _____
Problem Substance #4 _____ Sub 4 Frequency _____
Problem Substance #5 _____ Sub 5 Frequency _____

Frequency Codes
01 – Did Not Use
02 – 1 to 3 Times Monthly
03 – 1 to 2 Times Weekly
04 – 3 to 6 Times Weekly
05 – Daily
06 – Binge
88 – Unknown

Substances codes to use:

01 - None	08 - Heroin/Opium	15 - Steroids
02 - Alcohol	09 - Prescription Opioids	18 - Crack
03 - Cocaine	10 - Over the Counter Opioids	19 - Ecstasy
04 - Amphetamines/Other Stimulants Drug	11 - Hallucinogens	20 - Methamphetamines / Crystal Meth
05 - Cannabis	12 - Glue and Other Inhalant	
06 - Benzodiazepines (i.e. Valium, Ativan)	13 - Tobacco	88 - Unknown
07 – Barbiturates	14 - Other Psychoactive Drug	

Substances used in the past 12 months (please check ✓ those that apply)

❑ Alcohol	❑ Glue/Inhalant	❑ Benzodiazepines	❑ Steroids
❑ Tobacco	❑ Heroin/Opium	❑ Hallucinogens	❑ Undifferentiated
❑ Crack	❑ Ecstacy	❑ Script. Opioids	❑ None
❑ Cannabis	❑ Amphetamines	❑ Over-the-counter Codeine	❑ Unknown
❑ Cocaine	❑ Barbiturates	❑ Other Psycho-Act	

GAMBLING PROBLEM? ❑ No ❑ Yes

Gambling activities engaged in past 12 months (please check those that apply)

❑ Bingo	❑ Illegal	❑ Scratch	❑ Betting Outcomes
❑ Slot	❑ Horse	❑ Internet	❑ Other
❑ Gaming Machines	❑ Sports Betting	❑ Stock Market/Real Estate	❑ None
❑ Card Table	❑ Lottery	❑ Betting Games	❑ Unknown

HEALTH INFORMATION:
Please answer **Y** for Yes, **N** for No or **U** for Unknown to the following questions:

Number of overnight hospital stays in past 12 months for physical problem? _____

Diagnosed with mental health problem by *a qualified Mental* Health Professional?
Within Last 12 months? _____ Within lifetime? _____

Hospitalized for a mental health problem?
Within Last 12 months? _____ Within lifetime? _____

Received mental health treatment from a community Mental Health program or professional?
Currently? _____ Within Last 12 months? _____ Within Lifetime? _____

Prescribed medication for mental health problem?
Currently? _____ Within Last 12 months? _____ Within lifetime? _____

VISUALLY IMPAIRED ❑ No ❑ Yes **MOBILITY** ❑ No ❑ Yes
HEARING IMPAIRED ❑ No ❑ Yes **PREGNANT** ❑ No ❑ Yes

Are you currently in any type of treatment for counseling or emotional or mental health problems?
❑ No ❑ Yes ❑ Unknown

Psychiatrist/Psychologist _____ Phone _____

Known psychiatric disorders: _____

Is there a threat of harm to you or others? ❑ No ❑ Yes ❑ Unknown
If yes, what? _____

Is there any self injurious, cutting/burning and or punching? ❑ No ❑ Yes
If yes, please explain? _____

PSYCHIATRIC SYMPTOMS
❑ Fluctuating Mood (Mood Swings)
❑ Obsessive Compulsive Symptoms
❑ Phobia(s): _____
❑ Other Anxiety Symptoms
❑ Attention Deficit / Hyperactivity
❑ Elevated Mood
❑ Depressed Mood
❑ Sleep Disturbance
❑ Delusions
❑ Hallucinations
❑ Memory Impairment
❑ Personality Traits
❑ Substance Use
❑ Confusion
❑ Abnormal Eating Behaviours
❑ Panic Symptoms or Attacks

➔ **Which can be complicated by:**

PSYCHOSOCIAL ISSUES
❑ Financial Issues
❑ Parenting Issues
❑ Self Esteem
❑ Anger / Temper Control
❑ Bereavement
❑ Lack of Social Supports / Social Isolation
❑ Sexual Problem
❑ Current Physical / Sexual Abuse (Partner)
❑ Physical / Sexual Abuse during Childhood
❑ Past Physical / Sexual Abuse (Victim)

WHAT ARE THE CIRCUMSTANCES THAT LED YOU TO WANT TO COME TO TREATMENT?

PLEASE SEND ALL INQUIRIES AND COMPLETED REFERRALS TO

Central Intake c/o Nipissing Detoxification and Substance Abuse Programs
120 King Street West, Unit A, North Bay, ON P1B 5Z7
Phone: 705-476-6240 Ext. 6290 • Fax: 705-476-6136