APPLICATION FOR RESIDENTIAL TREATMENT

The Oaks Centre—Camillus Centre Residential Treatment Program

INSTRUCTIONS: The following form is required to begin the application process to the Camillus Centre Residential Treatment Program. The form should be printed and completed by hand, then faxed or mailed to Camillus Centre (info below). To schedule an assessment appointment, please contact our Intake Secretary at 705-848-2129 ext. 312.
Mailing Address: Intake Office 9 Oakland Blvd. Suite#3, Elliot Lake, ON P5A 2T1
Fax Number: Completed applications can be faxed to 705-461-8599, attention to Intake Office

OFFICE USE ONLY
Referred on: **Intake Scheduled on:**

START HERE

PERSONAL INFORMATION

First Name: Click here to enter text. Last Name: Click here to enter text.
Full name at birth (if different from above): Click here to enter text. Alternate name:Click here to enter text.
Date of Birth: Click here to enter a date. Gender: Choose an item.
Do you have a valid Ontario Health Card? Choose an item. Health Card Number: Click here to enter text.
Home Address: Click here to enter text. City: Click here to enter text. Province: Choose an item.
Postal Code: Click here to enter text. No Fixed Address? ☐YES ☐NO
Current Location (if different than above):
Phone Number: Click here to enter text. Okay to leave message? ☐YES ☐NO
Name of Emergency Contact: Click here to enter text. Relationship: Click here to enter text.
Emergency Contact Phone#: Click here to enter text. Okay to leave message? ☐YES ☐ NO
Language you prefer to receive English in? Click here to enter text. Ethnicity: Click here to enter text.

REFERRAL INFORMATION

Please check the boxes that explain who referred you to Camillus Centre:

☐Self	☐Day/Evening Addictions Services	☐Correctional Facility
☐Family/Friend	☐Psychiatric Services	☐Supportive Housing
☐Initial Assessment Treatment Planning	☐Psychiatrist/Psychologist	☐Self-Help Group
☐Withdrawal Management Centre	☐Medical Services	☐EAP/Employer
☐Community Withdrawal Management	☐Community Health Centre	☐Police
☐Residential Addictions	☐Physician/Private Practice	☐Other Legal
☐Non-Addictions Residential Services	☐Public Unit Nurse	☐DART/Connex Website
☐Outpatient Addictions	☐Community Mental Health	☐Other

Please specify Referring Agency (ies): Click here to enter text.
Contact name at Referring Agency (ies): Click here to enter text.

APPLICATION FOR RESIDENTIAL TREATMENT

EMPLOYMENT STATUS	☐(Self) Employed Full-Time ☐Disability ☐Employed Part-Time ☐ Retired ☐Unemployed (looking for work) ☐Student/Training ☐Not in Labour Force (ie. homemaker)
EDUCATION: (highest level achieved)	☐No formal schooling ☐Some Primary School ☐Completed Primary School ☐Some Secondary or Highschool ☐Completed Secondary or Highschool ☐Some College/CEGEP/Nursing ☐Completed College/CEGEP/Nursing ☐Some University (not complete) ☐Completed University Degree/Masters/PhD
INCOME SOURCE	☐Disability Insurance ☐Employment ☐Employment Insurance (E.I.) ☐Family Support ☐None ☐Ontario Disability (ODSP) ☐Ontario Works (OW) ☐Other ☐Other Insurance (excluding E.I.) ☐Retirement Income

PREVIOUS SUBSTANCE TREATMENT

Have you had previous substance treatment? ☐ Yes (if yes, complete chart below) ☐No

Treatment Facility/Location	Type of Treatment	Date Attended	Program Length

FAMILY BACKGROUND

Please identify your current relationship status:	☐Married ☐ Widow/Widower ☐Partnered/Common Law ☐ Divorced/Separated ☐Single (never married)
Birth Place:	

Please identify your immediate family members below:

Family Member Name	Relationship	Age	Do you have contact with them?	Are they supportive of treatment?	Do they abuse alcohol or drugs?

If you have children, please complete the information below:

Name of Child	Age	Who do they live with?

Are you currently involved with any of the following services (check more than one, if necessary):	☐Family & Children's Services ☐Children's Aid Society ☐First Nation Family Services ☐Other: _____

LEGAL STATUS

Legal Status:	☐No problems ☐Awaiting Trial or Sentencing ☐On probation	☐On parole ☐Incarcerated ☐Other: _____
Treatment Mandated/Required:	☐None / No Conditions ☐Choice of Treatment / Incarceration ☐Condition of Probation / Parole ☐Family & Children's Services Requirement	☐Condition of Employment ☐Condition of Family ☐Other: _____
Do you currently have Young Offender status?	☐Yes	☐No
Do you have any charges, fines or warrants outstanding or pending?	☐Yes	☐No
If yes, please explain:		
Please list any upcoming court dates:		
Are you currently participating in a Drug Treatment Court Program?	☐Yes	☐No

PHYSICAL HEALTH STATUS

Family Doctor Name (if applicable):	Doctor's Phone Number:
Please check any health issues that apply to you:	
☐Visual Impairment	☐Pregnant
☐Hearing Impairment	☐Communicable Diseases (ie. Hepatitis, HIV, etc)
☐Mobility Concerns	☐Acquired Brain Injury
Please describe your physical health concerns:	

Please list any allergies you have:

Please indicate the number of overnight hospitalizations **in the last 12 months** for physical problems:	
Please indicate the number of Emergency Department visits **in the last 12 months** for any issue:	
Have you ever injected drugs for non-medical use?	☐Never injected ☐Injected within the past year ☐Injected over a year ago
Have you been diagnosed with a developmental or learning disability?	☐Yes ☐No
If yes, please describe:	

MENTAL HEALTH STATUS

Have you been diagnosed with a mental health problem by a qualified mental health professional…		
…..within the last 12 months?	☐Yes	☐No
…..within your lifetime?	☐Yes	☐No
If yes, please explain:		
Have you been hospitalized for a mental health concern within the last 12 months?	Yes	No
Have you been hospitalized for a mental health concern within your lifetime?	Yes	No
Have you received treatment for a mental health, emotional, behavioral or psychological concern from a professional…..		
…..currently?	☐Yes	☐No
.....within the last 12 months?	☐Yes	☐No
…..within your lifetime?	☐Yes	☐No
Name of service provider:		
Contact info for service provider:		
Are you prescribed medication for mental health concerns…		
…..currently?	☐Yes	☐No
.....within the last 12 months?	☐Yes	☐No
…..within your lifetime?	☐Yes	☐No
Do you engage in self-harm behaviours?	☐Yes ☐No	If yes, when:
Have you ever attempted suicide?	☐Yes ☐No	If yes, when:
Have you ever overdosed?	☐Yes ☐No	If yes, when:

OPIOID SUBSTITUTION

Are you currently participating in an opioid substitution program?	☐Yes	☐No
If yes, please indicate which one:	☐Methadone	☐Suboxone
If yes, who is your prescriber?		
What is your current dosage?		

MEDICATIONS

Please indicate your current medication(s):	Please indicate your current dosage(s):
1.	
2.	
3.	
4.	
5.	
6.	

7.	
8.	

CURRENT SUBSTANCE USE

What are your current drugs of choice? Please list in order of severity.		Please indicate below how often you used in the last 30 days for each substance.	
1.		☐Did not use ☐1-3 times monthly ☐1-2 times weekly	☐3-6 times weekly ☐Daily ☐Binge
2.		☐Did not use ☐1-3 times monthly ☐1-2 times weekly	☐3-6 times weekly ☐Daily ☐Binge
3.		☐Did not use ☐1-3 times monthly ☐1-2 times weekly	☐3-6 times weekly ☐Daily ☐Binge
4.		☐Did not use ☐1-3 times monthly ☐1-2 times weekly	☐3-6 times weekly ☐Daily ☐Binge
5.		☐Did not use ☐1-3 times monthly ☐1-2 times weekly	☐3-6 times weekly ☐Daily ☐Binge

Please indicate any substances used in the past **12 months** (select all that apply):

Substance	Date Last Used	Method of Use	
Alcohol	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Amphetamines & other stimulants	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Barbiturates	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Benzodiazepines	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Cannabis	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Cocaine	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Crack	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Ecstasy / MDMA	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Glue / Inhalants	Click here to enter a date.	☐Smoked	☐Injected

		☐Snorted	☐Swallowed
Hallucinogens	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Heroin / Opium	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Methamphetamines (ie. crystal meth)	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Other psycho-active substances	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Over-the-counter codeine	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Prescription Opioids	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Steroids	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Tobacco	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
Other (please specify)	Click here to enter a date.	☐Smoked ☐Snorted	☐Injected ☐Swallowed
How old were you when you first tried any drug or alcohol			
How old were you when you first tried your current drug of choice?			

GAMBLING

Have you ever had gambling identified as a problem?			
Would you be interested in treatment for gambling?			
Please use the check boxes below to indicate any gambling activities engaged in the past 12 months:			
☐	Bingo	☐	Lottery tickets
☐	Slot machines	☐	Instant win or scratch tickets
☐	Gaming machines (other than slots)	☐	Internet gambling
☐	Casino card or table games	☐	Gambling with stock market or real estate
☐	Non-casino card or table games	☐	Betting on games of skill
☐	Horse races	☐	Betting on outcome of events
☐	Sports betting	☐	Other

SEMI PRIVATE / PRIVATE INSURANCE COVERAGE

Ward beds and accessible rooms are available as a standard option for our patients. Semi Private and Private rooms are available to those who have insurance coverage through their insurance carrier(s).

Please ensure all numbers you provide (i.e. policy, health card, etc.) are correct.

Your name as it appears on your Health Card: _____

Your Health Card Number: _____Province:_____ Expiry Date: _____

Do you have additional coverage? ☐No ☐Yes If yes, please fill out the required information below:

Name of Insurance Company/Carrier: Click here to enter text.

Name of Insured Person's Employer: Click here to enter text.

Job title of person insured: Click here to enter text.

Name and Date of Birth of Insured Person: Click here to enter text. D.O.B.: Click here to enter a date.

Address of Insured Person: Click here to enter text.

Policy Number:Click here to enter text. Group Certificate Number: Click here to enter text.

Insurance Carrier's Telephone Number: Click here to enter text.

Relationship to the Insured: Self: ☐ Spouse: ☐ Dependent: ☐

Do you have:
Private Hospital Bed ☐ Semi Private Hospital Bed ☐ OHIP Only ☐

For Office Use Only

Insurance Company contacted? _____Date:_____ Time:_____

Name of Person Spoken to:_____

Confirmed
Private Hospital Bed ☐ Semi Private Hospital Bed ☐ Health Card Only ☐ Refused (Reason) ☐
_____
_____
_____

Photocopy of Health Card (Front and Back) Yes ☐ No ☐ and Benefit Card (Front and Back) Yes ☐ No ☐
_____

Staff signature: _____ Date completed: _____

Thank you for completing the Oaks Centre Application Form