

Admission Request



Drumheller Society for Recovery (Grace House) Box 1785, 175 3rd Street West, Drumheller, AB T0J
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The Grace House offers a 90 – 120 day inpatient residential treatment program for adult males overcoming their problems with alcohol or other drugs. We are a program of complete abstinence, emphasizing the 12 steps as an individual path to sobriety and recovery.

FOR OFFICE USE ONLY: PLEASE DO NOT FILL THIS SECTION

Date received:	Admission Ranking comments:				
Phone				Fax	
E-Mail				In person	

Part 1: Identification Information

Last Name:		First name:		Middle name:	
Address:					
City:		Province:		Postal code:	
E-mail:					
Phone:		Alternate Phone:		Emergency contact:	
Contact Phone:					
Date of birth:		Age:		Marital status:	
Dependents:		Yes No			
Where were you born:				Highest completed level of Education:	
Do you have a valid Alberta drivers license?		Yes No		Are there any restrictions or infractions on it?	
Yes No				Yes No	
Do you have a SIN card?		Yes No		Do you have an Alberta provincial health care card?	
Yes No				Yes No	

Part 2: Referral and treatment Information

Note: Applicant must have a full 5 days of complete abstinence from drugs and alcohol prior to admission. No exceptions will be made to this criteria. All applicants are required to submit to a drug/alcohol test upon arrival and will be refused admission if they fail a test, refuse a test or show signs of recent use. All applicants should also note that there is a zero tolerance policy within our admission policy in regards to any clients who are on ANY mood altering medications. These medication include but are not limited to: METHADONE, LITHIUM, ABILIFY, etc.

Referral source:	Agency Contact:	Phone:	Fax:
I do hereby authorize the Grace house and the referring agency to share and verify any and all confidential information regarding this application and any information pertaining to my treatment history			Signature:

In the following section please provide details of most recent residential treatment facilities for drug or alcohol abuse:

Institution:	Approximate dates:	Reason for treatment:	If you failed to complete the program provide reason:

How many residential treatment programs have you attended?	How many of these programs have you completed?
What drug or alcohol problem are you seeking to recover from?	How long has this been a problem for you?
How long did you remain alcohol, drug or gambling free after treatment?	What are your reasons for wanting to attend residential treatment at this time?
Describe in detail how your drinking, drug taking and/or gambling has affected you and your life? (e.g. effects on family relationships, employment, health, social life, etc.)	
Other than alcohol, substances or gambling, what are other concerns that you may wish to address while in treatment?	

Do you have any concerns or challenges that may require additional support while you attend residential treatment programming? (e.g. reading and writing English, wheelchair accessibility, hearing difficulties, problems with stairs and long corridors)			
Yes ☐ No ☐			
Drug (alcohol, cocaine, opioids, etc.) and how used (ingested, injected, snorted, etc.)	How often was your usage? (daily, weekly, monthly)	Amount used:	Date of last use: (mm/dd/yyyy)

Part 3: Health and Medical Information

The Grace House is not a medical facility and may decline to admit men whose mental and physical concerns are beyond our capacity or scope as an organization to treat men and their issues with addictions. Any health concern that is not disclosed or documented may result in the resident being discharged or refused admission. Residents must be able to walk, feed, dress, bathe and care for themselves.

Are you on any medications? Yes ☐ No ☐

If you are on medication, please indicate what medication and for how long. Include herbal remedies, over the counter medications, vitamins, laxatives, and diet aids.

Medication / Dose	Route of delivery	Frequency	Reason	Start date	End date	Prescribing Physician	Phone number

The Grace House incorporates daily work in a group called "The Odd Job Squad" as part of our programming.
Do you have any medical or other reason that you cannot participate on the Odd Job Squad?

Yes ☐ No ☐

Have you ever experienced or been diagnosed with any of the following (Please check all that apply)					
Psychosis ☐ Depression ☐ Suicide attempts ☐ Post traumatic stress ☐ Anxiety/panic attacks ☐	Schizophrenia ☐ Bipolar ☐ Borderline personality ☐ Self harm ☐ ADD/ADHD ☐	Learning disability ☐ Fetal alcohol syndrome ☐ Other ☐			
Do you have any current health concerns such as listed below (Please check all that apply)					
Trouble walking ☐ Hearing/vision problems ☐ Arthritis/pain problems ☐ Asthma/allergies ☐ Breathing problems ☐ Hepatitis ☐	Staph infection ☐ High blood pressure ☐ Low blood sugar ☐ Diabetes ☐ Heart problems ☐ Epilepsy/seizures ☐	Tuberculosis ☐ Kidney or liver problem ☐ Scabies/lice/mites ☐ HIV/AIDS ☐ Sexually transmitted ☐ Sleep apnea ☐ Other ☐			
Do you have any allergies? (medications, foods, environmental)					
Describe current medical concerns (e.g. chronic health issues, recent surgery, injuries, pain, etc.)					
Have you ever experienced mental health concerns? (e.g. panic attacks, hallucinations/delusions, uncontrollable rage, mood swings, mental illness, etc.)					

Describe in detail how the above concerns affected you or others both in the past and currently. If currently under the care of a doctor/psychiatrist/psychologist, complete boxes below	
Doctors name:	Phone number:
Doctors name:	Phone number:
Doctors name:	Phone number:
Doctors name:	Phone number:

Medication Payment If you are on medications, how will you be paying for them? *Ensure you have file/policy numbers available to support medication payment if required*

Alberta Blue Cross		Other private insurance		FNIHB	
AISH		Alberta Works			
Self-Partial					
Cash		Certified Cheque		Visa or Mastercard	
Self-Full					
Cash		Certified Cheque		Visa or Mastercard	
Health Canada		Indian Affairs			

Have you had any thoughts of suicide or self-harm?

Yes

No

Part 4: Legal information

The Grace House does not accept residents who are on parole. If on probation matters need to be transferred to local office or dealt with via telephone. If you have any outstanding charges, these should be dealt with or deferred prior to admission. Time is not provided for attendance to court. Failure to disclose any legal issues could result in refusal of admission or dismissal from program.

Have you in the past been charged with a criminal offence? Yes No
If so please indicate below:

Offense :	When? (mm/yyyy)	Disposition:

If applicable, list upcoming court dates:

Are you currently incarcerated/in jail? If yes which institution?

Yes

No

Are you on Probation, Temporary Absence or Parole?

Yes

No

Type of Offence Name of Parole/Probation Officer

Parole/Probation Officer's Phone Parole/Probation Officer's Agency/Office

Is there anything else you feel we should know?

Part 5: Agreement & Disclosure

What is your source of income? (please check all that apply)

AISH

EI

Social services

Employment

Pension

Carefully read the following:

I acknowledge that all information is true and correct to the best of my knowledge. Failure to disclose accurate and complete information may result in my inadmissibility or discharge from the Grace House program. I understand in order to be admitted to residential treatment, I must remain alcohol and drug free for at least five days (length of time may vary based on assessment) prior to my admission date, and be well enough to participate in the program. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be referred to an appropriate detoxification setting before treatment. I understand Grace House is not responsible for my transportation or any other personal costs I may incur (*e.g. approved medications*) while I am in treatment. I will bring and give to staff all medications I am taking.

I understand I **cannot** schedule **any** appointments (legal, dental, medical or personal) for the period while in treatment. I must focus on my treatment program. I understand and agree to accept and attend all components of the treatment program as prescribed by AHS, including all workshops, lectures, leisure and group counseling sessions.

The personal information collected by this application is collected under the authority of section 33(c) of the Freedom of Information and Protection of Privacy Act and section 20 of the Health Information Act and will be used and disclosed by AHS for verifying the statements in this application and for determining admission to Residential Adult Addictions Treatment Program. If you have questions about this program, call one of the treatment centres. If you have any questions about AHS' privacy policies and practices, contact Information and Privacy at 1-877-476-9874. You may also write to Information and Privacy at 10301 Southport Lane SW, Calgary, Alberta T2W 1S7 or email us at privacy@albertahealthservices.ca

Signature:

Date:

Part 6: Contact information

Please provide contact information of where you can be reached if we have a bed available

PRIMARY CONTACT	PHONE NUMBER:	Name in Full:
SECONDARY CONTACT	PHONE NUMBER:	Name in Full:

WAITING LIST: Once you are on the waiting list, YOU ARE REQUIRED TO CALL IN ONCE PER WEEK. If you do not call in, you will be removed from the waiting list.

BED OFFERS: When a bed becomes available, we will call the last contact number you have left. YOU WILL HAVE 24 HOURS TO REPLY. If you fail to respond, we will move on to the next name and you will be removed from the waiting list.

If you connect with the Answering service when calling to check in or respond to a bed offer, please leave your name, number and reason for calling. THIS WILL ENSURE THAT YOUR RESPONSE IS RECORDED IN TIME.

Part 7: 3rd party Medical forms

Please note: The below forms must be completed by a medical examiner and submitted with your application prior to the client interview process.

Applicant's name:

Alberta Healthcare number:

Are you the Applicants regular Physician? Yes

No

A. Medical History: (explain any "Yes" responses in Section. B)

	Diagnosed		Tested		Comments
	Yes	No	Yes	No	
Central Nervous System Disorder					
Chronic Brochitis					
Asthma					
Heart problems					
Current BP					
Gastrointestinal problems					
Pancreatic problems					
Kidney or urinary problems					
Diabeties					
Epilepsy					
Tuberculosis					
Chronic pain					
Eating disorders					
Sleep disorders					
Withdrawl symptoms					
Mood disorders (e.g major depressive disorders)					
Psychotic disorders					
Liver problems: Hepatitis B & C					
HIV/AIDS					
Sexually transmted diseases					
Allergies					

Any other medical problems not listed:

B. Are there any specific problems that should be considered in the treatment of this Applicant:

C. Current Medications

Please list current medications (including perscription medications and over the counter drugs) you are aware that the applicant is taking. Please note that no mood altering medications will be allowed in residential treatment unless perscribed and monitored by a psychiatrist for managment of mental illness.

Medication / Dose	Route of delivery	Frequency	Reason	Start date	End date	Clinical indication

Reminder to physician: For the applicant's safety and wellness when in residential treatment, please arrange with his pharmacy for compliance with packaging of medication to take to treatment and perscribe sufficient quantities for the duration of the treatment.

Is the appliciant stabilized on Medication? Yes No

In the past six months has the applicant been using the medication appropriately? Yes No
If no then please explain:

Physicians Name: _____

Telephone number: _____

Date: _____

Address: _____

PRAC ID: _____

Fax: _____

Physicians signature: _____

Date: _____

Physicians stamp: