



Residential Addictions Treatment Program

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APPLICATION FORM (PAGE 1 OF 4)

Catalyst#: _____ **Referred:** dd _____ mm _____ yyyy _____

NBRH File: _____ **Referred:** dd _____ mm _____ yyyy _____

Client Information:

First Name: _____ **Middle Name:** _____

Last Name: _____ **Last Name at Birth:** _____

Alternate: _____ **D.O.B:** dd _____ mm _____ yyyy _____ **Age:** _____

Gender: Male Female **Health Card #:** _____

Street Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

County: _____ **Country:** _____

Home Phone: _____ OK to call: Y N OK to leave a message: Y N

Cell Phone: _____ OK to call: Y N OK to leave a message: Y N

Other Phone: _____ OK to call: Y N OK to leave a message: Y N

Current Location (if different from above) _____

Phone: _____ OK to call: Y N OK to leave a message: Y N

Emergency Contact: _____

Relation: _____ **Emergency Phone:** _____

Preferred Language: _____ **Ethnicity:** _____

Referral Information:

Referred: dd _____ mm _____ yyyy _____ **Referring Source:** _____

Referring Agency: _____ **Contact Person:** _____

Phone: _____

Are ADAT/GAINS Q3 tools completed? Y N In the Process

(If yes ask to receive Tracking Summary and Health Screening Form)



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APPLICATION FORM (PAGE 2 OF 4)

Legal Issues:

Treatment Mandated/Required by: _____

Legal status: _____

Probation Start: dd____ mm____ yyyy____ **Probation End:** dd____ mm____ yyyy____

Charges Pending: _____

Legal History: _____

Relationship Status: _____ **Education:** _____

Children: Y N **Employment Status:** _____ **Employer:** _____

Income Source: ODSP Disability Insurance Ontario Works Employment
 None Retirement Income Employment Insurance

Date of Last Cheque Received: dd____ mm____ yyyy____ **Amount:** \$ _____

Substance Use:

Presenting Problem Substances (Drugs of Choice) 1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly 4. 3-6 times weekly 5. Daily 6. Binge 7. Unknown

1. _____ Frequency in last 30 days: _____

2. _____ Frequency in last 30 days: _____

3. _____ Frequency in last 30 days: _____

4. _____ Frequency in last 30 days: _____

5. _____ Frequency in last 30 days: _____

Substances used in the past 12 months: _____

Gambling: Y N Unknown

Last Date Substance Used: dd____ mm____ yyyy____ **Substance:** _____

Previous Treatment: Y N If yes, when and where: _____

Recovery Homes: Y N If yes, when and where: _____



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APPLICATION FORM (PAGE 3 OF 4)

Health Status/Problems:

Visual Impairment: Y N Unknown **Hearing Impairment:** Y N Unknown

Mobility Impairment: Y N Unknown **Pregnant:** Y N Unknown N/A

Non medical injection use: Never Prior to 1 year Past 12 months Unknown

Number of overnight Hospitalizations in the last 12 months for physical problems: ____ Unknown

Reason for most recent Hospitalization: _____

Diagnosed with a Mental Health problem by a qualified Mental Health Professional?

Within the last 12 months: Y N Unknown Within lifetime: Y N Unknown

Most Recent Diagnosis #1: _____ Most Recent Diagnosis #2: _____

Hospitalized for a Mental Health problem?

Within the last 12 months: Y N Unknown Within lifetime: Y N Unknown

Received treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

Currently: Y N Unknown Within the last 12 months: Y N Unknown

Within lifetime: Y N Unknown

Name of service provider: _____ Phone: _____

Prescribed medication for a mental health problem?

Currently: Y N Unknown Within the last 12 months: Y N Unknown

Within lifetime: Y N Unknown

Name and dosage of medication: _____

Primary health care provider: _____ **Phone:** _____

Address: _____

Health Conditions/Problems/Allergies: _____

Methadone/Suboxone: Y N Unknown

Have you ever had a transmittable illness/disease: Y N Unknown

If yes, what: _____

