



REFERRAL PACKAGE  
To Be Completed By Referral Agency

SECTION A: PERSONAL DATA

Name: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 10 Digit Treaty # \_\_\_\_\_ S.I.N.: \_\_\_\_\_  
 M.H.S.C. # \_\_\_\_\_ P.H.I.N.: \_\_\_\_\_  
 Education: Last grade completed \_\_\_\_\_ On or Off Reserve \_\_\_\_\_  
 Language(s) Spoken: English \_\_\_\_\_ Cree \_\_\_\_\_ Dene \_\_\_\_\_ Ojibway \_\_\_\_\_ Other \_\_\_\_\_  
 Understand: English \_\_\_\_\_ Cree \_\_\_\_\_ Dene \_\_\_\_\_ Ojibway \_\_\_\_\_ Other \_\_\_\_\_

INFORMATION ON NEXT OF KIN:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
 Relationship to Program Applicant: \_\_\_\_\_

Why are you referring this client? \_\_\_\_\_  
 \_\_\_\_\_  
 How much contact have you had with the applicant? \_\_\_\_\_  
 Does the applicant recognize they have an addiction? \_\_\_\_\_  
 What pressures is the applicant faced with to enter treatment? \_\_\_\_\_  
 \_\_\_\_\_

**SECTION B: TREATMENT HISTORY**

Which other treatment centers has the applicant attended? Please specify dates and reasons for leaving. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION C: FAMILY HISTORY**

Marital Status: Married \_\_\_\_\_ Common-Law \_\_\_\_\_ Single \_\_\_\_\_

Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

List All Family Members Living At Home & Away From Home:

Name:	Sex:	Age:	Relationship to Client:	Living At Home:
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____

If applicable, what child care arrangements have been made while client is in treatment?

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY SUPPORT:**

1. How do the client's family members and significant others feel about the client coming into the 17-week treatment program? \_\_\_\_\_

\_\_\_\_\_

2. What type of support does the client have while attending this program? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SECTION C: FAMILY HISTORY continued

3. Please specify below any type of problems that the client has been experiencing in the past twelve months (Please check all those that apply):

Alcohol \_\_\_\_ Drug \_\_\_\_ Solvents \_\_\_\_ Gambling \_\_\_\_ Grieving/loss \_\_\_\_

Anger/Violence \_\_\_\_ Apprehension of Children \_\_\_\_ Custody Issues \_\_\_\_

Mental Health Problems \_\_\_\_ Employment Issues \_\_\_\_ Lack of Support \_\_\_\_

Abuse Issues \_\_\_\_ Suicide \_\_\_\_ Depression \_\_\_\_ Other: \_\_\_\_\_

If applicable, please describe last suicide thought/attempt: \_\_\_\_\_

\_\_\_\_\_

SECTION D: LEGAL STATUS

Please check the following that apply to the applicant:

Current or pending charges \_\_\_\_\_ Recognizance \_\_\_\_\_ Probation \_\_\_\_\_ Parole \_\_\_\_\_

Conditional or temporary release \_\_\_\_ Upcoming Court Dates: \_\_\_\_\_

Information of Lawyer/Probation Officer/Parole Officer (Please Print):

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

\*\*\* Provide a copy of conditions with application \*\*\*

SECTION E: REFERRAL AGENT'S INFORMATION

Name & Title: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date: \_\_\_\_\_

Please forward all information to:

Lottie Godin

Treatment Intake & Aftercare

Nelson House Medicine Lodge

Phone (204) 484-2256 ext.2242 or fax (204) 484-2016

\*\*\* Remember Applications will not be reviewed by the Screening Committee until all documents are completed \*\*\*



NELSON HOUSE  
MEDICINE LODGE  
PAVING THE RED ROAD TO WELLNESS

MEDICAL EXAMINATION REPORT

SECTION A: PHYSICIAN/HEAD NURSE INFORMATION

Name & Title: \_\_\_\_\_

Health Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

SECTION B: PATIENT'S PERSONAL DATA

Patient's Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ M.H.S.C. #: \_\_\_\_\_

Treaty #: \_\_\_\_\_ P.H.I.N.: \_\_\_\_\_

Allergies: \_\_\_\_\_

SECTION C: INCLUDE RESULTS OF LAB WORK

Date of Last Complete Physical: \_\_\_\_\_

Date of Last Pap/Prostate Check: \_\_\_\_\_

Result of Chest X-Ray: \_\_\_\_\_ Dental Check-Up: \_\_\_\_\_

HIV/AIDS: \_\_\_\_\_ Thyroid Function: \_\_\_\_\_

Complete Blood Count: \_\_\_\_\_

Urinalysis: \_\_\_\_\_

SECTION D: MEDICAL HISTORY

No. of Pregnancies: \_\_\_\_\_ Miscarriages? \_\_\_\_\_

No. of Dependents: \_\_\_\_\_ If so, when? \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

SECTION D: MEDICAL HISTORY continued

History of surgery? If so, please explain: \_\_\_\_\_

Is patient experiencing signs or symptoms of alcohol or drug withdrawal? \_\_\_\_\_.

Severity: Severe: \_\_\_\_\_ Moderate: \_\_\_\_\_ Mild: \_\_\_\_\_ None: \_\_\_\_\_.

Additional Comments: \_\_\_\_\_

Medication Prescribed: \_\_\_\_\_

In your medical opinion, do you feel this patient is physically able to participate in a 17 - week treatment program at this time?

Yes \_\_\_\_\_ No \_\_\_\_\_(If no, please check which of the following applies):

\_\_\_\_\_Requires Detoxification \_\_\_\_\_Requires Mental Health Assessment

\_\_\_\_\_Limited Mobility \_\_\_\_\_Other: (Please specify)

\*\*\* NOTE: We do not permit our clients to use any mind-altering substances while in treatment \*\*\*

Please indicate and specify which of the following problems the patient may be experiencing or has a family history of:

Health Problem:	Family History of:	Active for patient:
Anemia	_____	_____
Anxiety Disorder	_____	_____
Arthritis/Rheumatism	_____	_____
Back Problems	_____	_____
Cancer (Type)	_____	_____
Cardiovascular Problems	_____	_____
Diabetes: (Type 1 or 2)	_____	_____
Eating Disorder	_____	_____
Epilepsy/Seizure Disorder	_____	_____
Heart Problems	_____	_____
Kidney Problems	_____	_____
Liver Problems	_____	_____

SECTION D: MEDICAL HISTORY continued

	Family History of:	Active for patient:
Mental Health Problems	_____	_____
Migraine Headaches	_____	_____
Respiratory Problems	_____	_____
Insomnia/Sleep Disorder	_____	_____
S.T.D.'s	_____	_____
Thyroid Problems	_____	_____
Tuberculosis	_____	_____

Nutritional Deficiencies? \_\_\_\_\_.

Were vitamins/supplements prescribed? \_\_\_\_\_.

Do you recommend any diet conditions? \_\_\_\_\_.

Is patient able to participate in the physical component of our program? \_\_\_\_\_.

\_\_\_\_\_  
Physician's/Nurse In Charge Signature

\_\_\_\_\_  
Date: