North Bay Recovery Home
APPLICATION FORM

Catalyst #: _____ Referred: dd_____ mm_____ yy_____

NBRH File: _____ Interview: dd_____ mm _____ yy _____

CLIENT INFORMATION			
First Name:		Middle Name:	
Last Name:		Last Name at Birth:	
Alternate:	D.O.B: dd _____ mm _____ yy _____		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 than 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 on: dd _____ mm _____ yy _____	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)

LEGAL ISSUES

Treatment Mandated/Required by:	
Legal Status:	Young Offender: Y N Unknown
Probation Start: dd ____ mm _____ yyyy _____	Probation End: dd ____ mm _____ yyyy _____
Charges Pending:	Legal History:
Relationship Status:	Education:
Children :	Employment Status : Employer :
Income Source: Disability Insurance Employment Wage Employment Insurance ODSP Ontario Works Retirement Income Other Insurance None Unknown	
Date of last cheque received: dd____ mm ____ yyyy _____	Amount: $ _____

REMIND CLIENT TO BRING WITH THEM UPON ADMISSION THEIR LAST CHEQUE STUB THOSE WHO QUALIFY MAY RECEIVE A COMFORT ALLOWANCE

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:_____

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 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/Opioid Substitute:
Y N Unknown

Have you ever had a transmittable illness/disease: Y N Unknown
If yes, what:

Current Medications:

Name: _____ Dosage: _____ Frequency: _____ Purpose: _____

Name: _____ Dosage: _____ Frequency: _____ Purpose: _____

Name: _____ Dosage: _____ Frequency: _____ Purpose: _____

Name: _____ Dosage: _____ Frequency: _____ Purpose: _____

Name: _____ Dosage: _____ Frequency: _____ Purpose: _____

FAMILY HISTORY

_____

_____

_____

OTHER INFORMATION

_____

_____

_____

OFFICE USE ONLY

Assessed by: □ Angela □ Dan	Assessment Recommendations: _____ _____
Scale: 1 2 3 4 5	Placed on wait list Date placed: dd _____ mm _____ yyyy _____ Date given to be admitted: dd _____ mm _____ yyyy _____ Does not qualify; reason: _____

WAITING LIST NOTES

_____

_____

_____

_____

Admitted to: Residential Outpatient Aftercare Date: dd_____ mm _____ yyyy _____