

# MIGISI ALCOHOL AND DRUG TREATMENT CENTRE ADULT INTAKE/REFERRAL FORM

**ALL SECTIONS MUST BE COMPLETED**  
**INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**

*If any information is not applicable: indicate as NA; unknown as UNK; unavailable as UNA.*

<b>A. General Information</b>																			
Date Application Received by Community Worker					Date Application Received by Treatment Centre														
Surname:			First Name:			Nickname or other name known by:													
Date of Birth:		Age:		Sex:		Provincial Health Card Number:													
Address:							Telephone:												
Language Spoken:			Language Preferred:			Language Understood:													
Emergency Contact Name:					Telephone:		Relationship:												
Nation Status:		Status Number: (10-digit registration number)				Band Name:													
		<table border="1" style="width: 100%; text-align: center;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																	
Education Level <input type="checkbox"/> Less than Gr. 8 <input type="checkbox"/> Completed High School <input type="checkbox"/> Not Completed High School <input type="checkbox"/> Completed Post-secondary <input type="checkbox"/> Some Post-secondary					Literacy: <input type="checkbox"/> Literate <input type="checkbox"/> Illiterate <input type="checkbox"/> Needs assistance		Employment Status:												
<b>Family/Relationships</b>																			
Marital Status: <input type="checkbox"/> Common-law <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed																			
Does Client have dependent children?					<input type="checkbox"/> Yes <input type="checkbox"/> No														
If yes, do they have access to adequate childcare while in treatment?					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable														
Are the children in care?					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable														
Does the client have other dependents?					<input type="checkbox"/> Yes <input type="checkbox"/> No														
Family Supports:																			
Family Strengths:																			
<b>Legal Status</b>																			

Most recent involvement in the justice system at entry	<input type="checkbox"/> No Involvement <input type="checkbox"/> Criminal Court <input type="checkbox"/> Family Court <input type="checkbox"/> Drug Court Treatment <input type="checkbox"/> Probation <input type="checkbox"/> Charges Pending <input type="checkbox"/> Court Referral <input type="checkbox"/> Court Order <input type="checkbox"/> Restorative Justice			
Has client been court ordered to attend treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide details (include details/copy of Probation Order if applicable and/or available):				
Is the client under any of the following legal conditions?	<input type="checkbox"/> Bail <input type="checkbox"/> Parole <input type="checkbox"/> Temporary Absence Order <input type="checkbox"/> Probation Order			
Other (provide details, dates, etc.):				
<b>Treatment History</b>				
Has client participated in a non-residential/community based substance abuse program?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has client participated in a non-residential/community based mental health program?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has client participated in a residential treatment program before?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide information on previous treatment experience:				
Year	Treatment Centre	Type of Addiction	Completed	Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason(s) for currently requesting treatment:				
<b>B. Withdrawal Symptoms:</b>				
<i>Has the client experienced any of the following symptoms while withdrawing from substances in the last 6 months?</i>				
<b>Symptom</b>		<b>Describe</b>		
<b>Blackouts:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown				
<b>Hallucinations:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown				
<b>Nausea/Vomiting:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown				
<b>Seizures:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown				
<b>Shakes:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown				
<b>Delirium Tremens (DT's):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown		<b>Ever experience DT's?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

**C. Process/Behavioral Addictions***Has client experienced problems with any of the following?*

Process/Behavioral Addiction	Describe
<b>Gambling (slots, cards, Keno, bingo, etc)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Eating (obesity, anorexia, bulimia, etc.)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Sex (promiscuity, etc.)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Internet/texting</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	

**D. Mental Health Issues***Provide the following information about the client's health status*

Mental Illness	Describe
<b>Been diagnosed with a mental illness</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Currently being treated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Currently on psychiatric medication</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Taking medication consistently</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
<b>Previous suicide attempts/ideation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
If yes, when?	
<b>Hospitalized for suicide attempts</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
If yes, when?	
<b>Currently suicidal</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	
Name of psychiatrist/psychologist (if applicable):	



**E. Other Issues/Needs**

Does client have cultural and/or spiritual beliefs and practices we need to be aware of? If yes, please describe:

☐ Yes  
☐ No

Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe:

☐ Yes  
☐ No

Are there any other significant issues we need to be aware of? If yes, please describe:

☐ Yes  
☐ No

Does the client understand Migisi Treatment Centre has a 3 strike policy in effect; and not following the Expectations (house rules) of Migisi Treatment Centre can result in a discharge of treatment?

☐ Yes  
☐ No

Does client understand there is an expectation they have been alcohol and drug free for at least 10 days prior to admission to residential treatment (or 14 days if withdrawing from benzodiazepines). (Client with less than the required days must notify the treatment Centre prior to admission).

☐ Yes  
☐ No

Personal Strengths:

**F. Application Checklist**

Confirmation of transportation to Treatment Centre through referral

☐ Yes  
☐ No

Confirmation of transportation back home

☐ Yes  
☐ No**Client has been notified and understands the Non-Insured Health Benefits policy change whereby anytime during treatment and the client self-terminates, or the Treatment Centre terminates the client, and medical transportation benefits have been provided, the client will have to assume the costs of the next trip to access medically required health services and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada.**☐ Yes  
☐ No**Client Authorization**

I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by the Treatment Centre.

**Client Signature****Date****Referral Signature****Date****REFERRAL INFORMATION**

Name of Referral:

Title/Position

Name of Referral Agency:

Address:

Postal Code:

Phone No:

Fax:

Will you continue to see the client once he/she has completed treatment?

☐ Yes ☐ No

What other supports would be available to your client in their community upon completion of treatment?

**Name/Resource****Description of Support**

<b>Client's Stage of Readiness:</b>		
<input type="checkbox"/> Pre-contemplation - Not considering change; resistant to change <input type="checkbox"/> Contemplation - Unsure of whether or not to change; chronic indecision <input type="checkbox"/> Determination - Preparation; committed to changing behaviour within one month <input type="checkbox"/> Action - Begin changing behavior <input type="checkbox"/> Maintenance - Behavior change has persisted for 6 months or more		
Please list any questions or concerns the client has indicated during the intake process:		
What other areas might need to be addressed in treatment? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):		
Referral Agent assessment of client's strengths and potential challenges for completing treatment:		
<b>Referral Checklist: Please initial each item that has been completed:</b>		
Please check items attached to this application		
<b>Item</b>	<b>Attached</b>	<b>Initials</b>
Application (completed thoroughly)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Assessment Form (completed by a medical examiner)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Expectations (Reviewed & Signed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AMIS Consent (Reviewed & Signed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DUSI-R: Substance Abuse Profile/Assessment (All questions completed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Information (Assessments, Legal documents, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please initial each item that has been completed:</b>		<b>Initials</b>
Confirmation of transportation to the treatment Centre		
Confirmation of transportation back home after completion of treatment		
All medical, dental and optical appointments have been dealt with prior to treatment		
All financial matters have been dealt with prior to treatment		
All legal matters have been dealt with prior to treatment		
Referral Signature	Date (D/M/Y)	

**MIGISI ALCOHOL AND DRUG TREATMENT CENTRE**  
**EXPECTATIONS**

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**1. ALCOHOL AND DRUGS:**

The use or possession of alcohol or drugs while in treatment is strictly prohibited. A search for drugs and/or inappropriate materials will be conducted and confiscated. Failure to comply will result in immediate dismissal. Random room checks will be made by Program Staff at any time.

**2. VIOLENCE / AGRESSION:**

Violence against persons and/or property is prohibited. Residents threatening anyone, fighting or destroying property will be discharged. ACTS OF INTIMIDATION towards another resident or staff will result in immediate dismissal from the program. Weapons are strictly prohibited. Anyone found in possession of a weapon will be immediately discharged.

**3. RELATIONSHIPS:**

Any intimate/sexual relationships between residents, visitors or staff will not be tolerated. All involved parties will be discharged under the suspicion or observance of these relationships developing.

**4. HEALTH AND SAFETY:**

- a. Absolutely NO SMOKING anywhere in the two buildings (dorm and administration).
- b. Smoking is allowed outside only at designated areas; please ensure cigarette butts are placed in cans provided.
- c. Residents must not hang towels, etc. over lamps as this may result in a fire.
- d. Absolutely NO FOOD/BEVERAGES during programming at any time. This includes gum and candy.
- e. NO FOOD/BEVERAGES are allowed in the dorm or lecture room at any time.
- f. Upon arrival, all medication must be handed to staff. Staff will witness as client dispense medication.
- g. Residents are expected to exercise good personal hygiene such as daily showers and clean clothes. Laundry facilities are available.
- h. Residents must use the bed assigned. Beds must be made every morning and rooms cleaned before breakfast.
- i. Residents are assigned daily chores and are expected to clean up after themselves at **ALL TIMES**. Failure to comply will result in loss of privileges or could result in a staff-discharge.
- j. Periodic room checks by the Program Staff are made throughout the night to ensure the safety and well-being of residents. Doors must remain open throughout the night, if applicable. Residents are expected to report any problems to the Program Staff.

## ***EXPECTATIONS: CONTINUED***

- k. The Fire drill procedure is posted in the dorm and main building:
  - i. Close all windows and doors if possible, then leave through the **NEAREST EXIT**;
  - ii. Walk quickly, please **DO NOT** run;
  - iii. Walk to the **PARKING LOT- EAST DOOR** and **approximately 100 feet away**;
  - iv. Wait until **ATTENDANCE** has been completed and permission is given to return to the building;
  - v. **ALWAYS** leave the building when you hear the **ALARM** go off.
- l. Absolutely **NO SWIMMING IN THE LAKE OR WALKING ON THE ICE OR DOCK AREA** at any time

### **5. SCHEDULE AND ATTENDANCE:**

- a. Residents must be up at 6:30 a.m. each day. After breakfast, chores are to be completed immediately. All residents must report to the Lecture Room at 9:00 a.m. for meditation and purification ceremony.
- b. Quiet hours are from 10:30 p.m. - 6:30 a.m. Dorm lounge will be closed during this time.
- c. Lights out at 10:30 p.m. each night.
- d. Absolutely **NO SLEEPING** during the day. Unless authorized by Program staff.
- e. All residents are to refrain from staying in their rooms during the day. Exceptions are made only for bathroom uses.
- f. Bedroom doors must be open at all times during the day except when showering or changing. ***ABSOLUTELY NO VISITING IN THE BEDROOMS.***
- g. Residents must attend all sessions. Residents who miss sessions or are late will lose privileges or will be discharged.
- h. **Meal Schedule (Please be punctual):**

Breakfast	7:00 am - 7:30 am
Lunch	12:00 pm - 12:30 pm
Supper	4:30 pm - 5:00 pm
Snack Time	During evening (free time)

***PLEASE NOTE: Unless a client is on a special diet, everyone will eat what is served***

### **6. LAUNDRY:**

Residents are expected to share the laundry facilities. The laundry room will be open at 6:30 am to 10:00 pm. Each room is assigned a different day beginning with Room #1 on Monday and ending with Room #7 on Sunday. Residents are responsible for their own linen and please remember to use full loads.

### **7. ADMINISTRATION OFFICE:**

Residents must not loiter around the reception area except when getting medication, when meeting with their Counselor, meeting with support workers or making purchases. Residents must ask receptionist if their Counselor is available.

## ***EXPECTATIONS CONTINUED:***

### **8. STAFF/SELF DISCHARGE:**

- a. **Self-Discharge (voluntary):** When a resident leaves treatment on his/her own. There is a waiting period of six (6) months before he/she can return. All clients are required to sign a voluntary discharge.
- b. **Staff-Discharge:** When a resident is discharged by the staff. There is a waiting period of twelve (12) months for re-admission.

### **9. DAILY WALKS:**

WALKS ARE MANDATORY. They are to be taken after meals, when chores are completed. There must be two or more residents for all walks during the day. The boundary for all walks/jogs is to the junction where the 'Migisi/Youth & Elders Centre' sign is posted.

### **10. VISITORS:**

Residents must notify staff in advance the names of all incoming visitors.

- a. Visiting hours are from 1:00 pm – 4:00 pm on Saturdays after two (2) complete weeks of treatment.
- b. Visitors under the influence of alcohol or drugs will be asked to leave the premises.
- c. Visiting is confined to the **dining room area only**.

### **11. OTHER**

- a. **No Jackets or hats** are to be worn during sessions. Sunglasses must not be worn in the buildings.
- b. Residents must dress appropriately. No clothing advertising alcohol and/or drugs.
- c. Gambling is prohibited during treatment.
- d. Residents must keep staff informed of their whereabouts at all times. No unauthorized outings.
- e. Residents are encouraged to interact and socialize with one another.
- f. Any abusive, vulgar or assaultive language could result in loss of privileges, or a staff-discharge.
- g. **NO SMOKING** in the main building, dorm, or in the van at any time.
- h. Cell Phones, iPods, iPads, musical instruments, razors, lighter fluid, butane refills, etc. will be turned in on arrival. They will be returned upon completion of treatment.
- i. MIGISI STAFF are not responsible for articles or clothing left behind.
- j. No music, television or outside reading material during treatment.
- k. All clients/residents are requested to leave their personal vehicles at home as they are not allowed on the premises. Other transportation arrangements must be made when coming to the Centre.
- l. No writing on the Migisi van or any vehicle parked in the parking lot.

### **3 STRIKE POLICY:**

***3 infractions of the expectations list will result in an automatic dismissal by staff***

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PLEASE SIGN AND DATE TO INDICATE THE REFERRAL AND APPLICANT HAVE READ AND UNDERSTAND MIGISI  
TREATMENT CENTRE'S EXPECTATIONS:

*(Please attach signature page with application upon submission)*

EXPECTATIONS
As a resident and/or applying applicant of Migisi Alcohol and Drug Treatment Centre, I have read and understand the treatment expectations, and I hereby fully agree to abide by them.
Resident Signature:
Referral Worker Signature:
Date:

**Ordinarily, how many times each month have you used each of the following drugs in the past year?  
(NOTE: if you only used a drug a few times over this past year, answer '0 times')**

**Alcohol**

- |  |                               |                                 |                                 |                                   |  |
|--|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 1. Beer, Wine, Liquor  | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 2. Non-Potable Alcohol - Hairspray, Sanitizer, Mouthwash, Aftershave | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Stimulants**

- |                                   |                               |                                 |                                 |                                   |  |
|-----------------------------------|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 3. Cocaine, Uppers, Khat          | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 4. Methamphetamine - Crystal Meth | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 5. Methamphetamine - Ice/Glass    | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 6. Methamphetamine - Speed        | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Caffeine**

- |  |                               |                                 |                                 |                                   |  |
|--|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 7. Coffee, Tea, Soda/Pop, Energy Drinks, Chocolate | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 8. Over the counter Cold Remedies                  | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 9. Over the counter Weight Loss Aids               | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Opioids**

- |  |                               |                                 |                                 |                                   |  |
|--|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 10. Prescription Suboxone                                | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 11. Prescription Methadone                               | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 12. Prescription Oxycontin, Oxycodone, Codeine, Morphine | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 13. Non-Prescription Oxycontin                           | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 14. Non-Prescription Oxycodone                           | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 15. Non-Prescription Codeine                             | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

- |                               |                               |                                 |                                 |                                   |  |
|-------------------------------|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 16. Non-Prescription Morphine | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 17. Non-Prescription Heroin   | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 18. Diverted Methadone        | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 19. Diverted Suboxone         | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Sedatives, hypnotics, or anxiolytics**

- |  |                               |                                 |                                 |                                   |  |
|--|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 20. Benzodiazepines                    | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 21. Barbiturates                       | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 22. Sleeping Medications               | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 23. Antianxiety Medications            | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 24. Prescribed Sleeping Medications    | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 25. Prescribed Antianxiety Medications | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Hallucinogens (phencyclidine)**

- |   |                               |                                 |                                 |                                   |  |
|---|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 26. Phencyclidine - PCP, Angel Dust, Ketamine, Cyclohexamine, Disocilpine   | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 27. Other - LSD, Mescaline, MDMA/Ecstasy, DOM/STP, DMT, Magic Mushrooms, Morning Glory Seeds, Jimson Weed, Salvia Divinorum | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Cannabis**

- |                             |                               |                                 |                                 |                                   |  |
|-----------------------------|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 28. Marijuana/Pot/Weed/Hash | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 29. Shatter                 | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 30. Prescribed Cannabis     | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |



- |   |                               |                                 |                                 |                                   |  |
|---|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 31. Prescribed CBD                            | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 32. Synthetic Cannabis - K2, Spice and others | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Inhalants**

- |                                   |                               |                                 |                                 |                                   |  |
|-----------------------------------|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 33. Glue                          | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 34. Gas/Fuels, Butane Lighters    | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 35. Paint, Paint Thinner, Lacquer | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 36. Propane                       | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 37. Aerosols                      | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 38. Other Volatile Compounds      | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Tobacco**

- |                       |                               |                                 |                                 |                                   |  |
|-----------------------|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 39. Smoking           | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 40. Chewing           | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
| 41. Smokeless Tobacco | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |

**Other (or unknown)**

- |  |                               |                                 |                                 |                                   |  |
|--|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|
| 42. Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas | <input type="radio"/> 0 times | <input type="radio"/> 1-2 times | <input type="radio"/> 3-9 times | <input type="radio"/> 10-20 times | <input type="radio"/> more than 20 times |
|--|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|--|

- |   |   |
|---|---|
| 43. Which drug caused you the most problems? (circle one) | <p>None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/Aftershave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxone, Benzodiazepines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstasy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer, Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas</p> |
|---|---|

44. Which drug do you prefer the most? (circle one)
- None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/After shave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxone, Benzodiazepines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstasy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer, Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas

**Answer ALL of the following questions. Even if a question does not apply exactly, answer according to whether it is MOSTLY YES (TRUE) or MOSTLY NO (FALSE). Answer the questions as they apply to you within the past year and leading up to the present time. If a question does not apply to you, answer NO.**

- |  |  |
|--|--|
| 45. * Have you had a craving or very strong desire for alcohol or drugs?   | <input type="radio"/> Yes <input type="radio"/> No |
| 46. * Have you had to use more and more drugs or alcohol to get the effect you want?   | <input type="radio"/> Yes <input type="radio"/> No |
| 47. * Have you felt that you could not control your alcohol or drug use?   | <input type="radio"/> Yes <input type="radio"/> No |
| 48. * Have you felt that you were "hooked" on alcohol or drugs?  | <input type="radio"/> Yes <input type="radio"/> No |
| 49. * Have you missed out on activities because you spend too much money on drugs or alcohol?                                      | <input type="radio"/> Yes <input type="radio"/> No |
| 50. * Did you break rules, miss curfew, or break the law because you were high on alcohol or drugs?                                | <input type="radio"/> Yes <input type="radio"/> No |
| 51. * Did you change rapidly from very happy to very sad or from very sad to very happy because of drugs?                          | <input type="radio"/> Yes <input type="radio"/> No |
| 52. * Have you had a serious argument or fight with a friend or a family member because of your drinking or drug use?              | <input type="radio"/> Yes <input type="radio"/> No |
| 53. * Have you had trouble getting along with any of your friends because of alcohol or drug use?                                  | <input type="radio"/> Yes <input type="radio"/> No |
| 54. * Have you experienced any withdrawal symptoms following use of alcohol or drugs (e.g., headaches, nausea, vomiting, shaking)? | <input type="radio"/> Yes <input type="radio"/> No |
| 55. * Have you had a problem remembering what you had done while you were under the effects of drugs or alcohol?                   | <input type="radio"/> Yes <input type="radio"/> No |
| 56. * Did you drink large quantities of alcohol when you went to parties?  | <input type="radio"/> Yes <input type="radio"/> No |
| 57. * Did you have trouble resisting using alcohol or drugs?   | <input type="radio"/> Yes <input type="radio"/> No |
| 58. * Have you ever told a lie in your lifetime?   | <input type="radio"/> Yes <input type="radio"/> No |
| 59. * Did you argue a lot?   | <input type="radio"/> Yes <input type="radio"/> No |
| 60. * Did you yell a lot?  | <input type="radio"/> Yes <input type="radio"/> No |
| 61. * Were you suspicious of other people?   | <input type="radio"/> Yes <input type="radio"/> No |
| 62. * Did you have a bad temper?   | <input type="radio"/> Yes <input type="radio"/> No |



- |       |   |                       |     |                       |    |
|-------|---|-----------------------|-----|-----------------------|----|
| 63. * | Were you easily upset?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 64. * | Did you do things a lot without first thinking about the consequences?                                      | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 65. * | Did you generally feel angry?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 66. * | Were you a loner?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 67. * | In your lifetime, do you behave better when you are around people you don't know?                           | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 68. * | Did you either sleep too much or too little?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 69. * | Have you either lost or gained more than 10 pounds?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 70. * | Did you have less energy than you think you should have?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 71. * | Did you have trouble with your breathing or with coughing?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 72. * | Did you have any concerns about sex or trouble with your sex organs?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 73. * | In your lifetime, did you ever feel that you wanted to swear?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 74. * | Did you get frustrated easily?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 75. * | Did you have trouble concentrating?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 76. * | Did you feel sad a lot?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 77. * | Have you been nervous?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 78. * | Did you worry a lot?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 79. * | Did you have trouble getting your mind off things?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 80. * | Did people stare at you?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 81. * | Have you ever felt tempted to steal something in your lifetime?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 82. * | Were you afraid to stand up for your rights?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 83. * | Were you easily influenced by other people?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 84. * | Did you have difficulty standing up for your opinions?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 85. * | Did you have trouble saying "no" to people?   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 86. * | Has your mood ever changed in your lifetime?  | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 87. * | Did you have frequent arguments with your children, parents or spouse which involved yelling and screaming? | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 88. * | Did you argue with your parents or your spouse or other family members a lot?                               | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 89. * | Were your parents or your spouse often unaware of where you were and what you were doing?                   | <input type="radio"/> | Yes | <input type="radio"/> | No |
| 90. * | Did you feel that either your parents or your spouse don't care about you?                                  | <input type="radio"/> | Yes | <input type="radio"/> | No |

- |  |  |
|--|--|
| 91. * Were you unhappy about your living arrangements?                                       | <input type="radio"/> Yes <input type="radio"/> No |
| 92. * In your lifetime, did you ever get angry?  | <input type="radio"/> Yes <input type="radio"/> No |
| 93. * Did you dislike school?  | <input type="radio"/> Yes <input type="radio"/> No |
| 94. * Did you have trouble concentrating in school or when studying?                         | <input type="radio"/> Yes <input type="radio"/> No |
| 95. * Were your grades below average?  | <input type="radio"/> Yes <input type="radio"/> No |
| 96. * Did you cut/skip school more than two days a month?                                    | <input type="radio"/> Yes <input type="radio"/> No |
| 97. * Were you absent from school a lot?   | <input type="radio"/> Yes <input type="radio"/> No |
| 98. * Have you thought seriously about quitting school?                                      | <input type="radio"/> Yes <input type="radio"/> No |
| 99. * Did you often not do your school assignments?  | <input type="radio"/> Yes <input type="radio"/> No |
| 100. * Were you often late for class?  | <input type="radio"/> Yes <input type="radio"/> No |
| 101. * Did you feel irritable and upset when in school?                                      | <input type="radio"/> Yes <input type="radio"/> No |
| 102. * Were you bored in school?   | <input type="radio"/> Yes <input type="radio"/> No |
| 103. * Were your grades in school worse than they used to be?                                | <input type="radio"/> Yes <input type="radio"/> No |
| 104. * Have you failed a grade in school?  | <input type="radio"/> Yes <input type="radio"/> No |
| 105. * Did you feel unwelcome in school clubs or extracurricular activities?                 | <input type="radio"/> Yes <input type="radio"/> No |
| 106. * Has your use of alcohol or drugs interfered with your homework or school assignments? | <input type="radio"/> Yes <input type="radio"/> No |
| 107. * Have you been suspended?  | <input type="radio"/> Yes <input type="radio"/> No |
| 108. * In your lifetime, did you ever put things off that you needed to do?                  | <input type="radio"/> Yes <input type="radio"/> No |
| 109. * Have you stopped working at a job because you just didn't care?                       | <input type="radio"/> Yes <input type="radio"/> No |
| 110. * Have you made money doing something that was against the law?                         | <input type="radio"/> Yes <input type="radio"/> No |
| 111. * Have you used alcohol or drugs while working on a job?                                | <input type="radio"/> Yes <input type="radio"/> No |
| 112. * Have you been fired from a job because of drugs?                                      | <input type="radio"/> Yes <input type="radio"/> No |
| 113. * Did you mostly work so that you can get money to buy drugs?                           | <input type="radio"/> Yes <input type="radio"/> No |
| 114. * In your lifetime, are you more happy if you win than lose a game?                     | <input type="radio"/> Yes <input type="radio"/> No |
| 115. * Did any of your friends regularly use alcohol or drugs?                               | <input type="radio"/> Yes <input type="radio"/> No |
| 116. * Did any of your friends sell or give drugs away?                                      | <input type="radio"/> Yes <input type="radio"/> No |
| 117. * Did any of your friends lie a lot?  | <input type="radio"/> Yes <input type="radio"/> No |
| 118. * Did your parents or spouse dislike your friends?                                      | <input type="radio"/> Yes <input type="radio"/> No |



119. * Have any of your friends been in trouble with the law?	<input type="radio"/> Yes <input type="radio"/> No
120. * Did your friends cut school or work a lot?	<input type="radio"/> Yes <input type="radio"/> No
121. * Did your friends get bored at parties when there was no alcohol served?	<input type="radio"/> Yes <input type="radio"/> No
122. * Have your friends brought drugs to parties?	<input type="radio"/> Yes <input type="radio"/> No
123. * Have your friends stolen anything from a store or damaged property on purpose?	<input type="radio"/> Yes <input type="radio"/> No
124. * Have you ever in your lifetime been talked into doing something you didn't want to do?	<input type="radio"/> Yes <input type="radio"/> No
125. * Did you usually stay out late on nights when you had to go to school or work the next morning?	<input type="radio"/> Yes <input type="radio"/> No
126. * Were you bored most of the time?	<input type="radio"/> Yes <input type="radio"/> No
127. * Compared to most people, were you less involved in hobbies or outside interests?	<input type="radio"/> Yes <input type="radio"/> No
128. * Were you dissatisfied with how you spend your free time?	<input type="radio"/> Yes <input type="radio"/> No
129. * Have you ever bought anything in your lifetime that you did not need?	<input type="radio"/> Yes <input type="radio"/> No
130. * Have you felt your cultural identity doesn't matter?	<input type="radio"/> Yes <input type="radio"/> No
131. * Have you had frequent nightmares?	<input type="radio"/> Yes <input type="radio"/> No
132. * Have you felt helpless to change your life?	<input type="radio"/> Yes <input type="radio"/> No
133. * Have you experienced frequent emotions like fear, anger, guilt, or shame?	<input type="radio"/> Yes <input type="radio"/> No
134. * Have you frequently thought about ending your life?	<input type="radio"/> Yes <input type="radio"/> No
135. * Have you felt alienated from family, friends, or community?	<input type="radio"/> Yes <input type="radio"/> No
136. * Have you harmed yourself (cutting, scratching, etc.)?	<input type="radio"/> Yes <input type="radio"/> No
137. * Have you felt guilty about experiencing pleasant emotions?	<input type="radio"/> Yes <input type="radio"/> No
138. * Have you felt overwhelmed by upsetting memories?	<input type="radio"/> Yes <input type="radio"/> No
139. * Have you felt betrayed by others?	<input type="radio"/> Yes <input type="radio"/> No
140. * Have you lacked motivation to care for your health (diabetes, heart, diet, exercise, hygiene)?	<input type="radio"/> Yes <input type="radio"/> No

**OFFICE USE ONLY**

**Date of Completion** \_\_\_\_\_

**NOTES:**

### **CONSENT TO COLLECT AND SHARE TREATMENT INFORMATION**

**MIGISI ALCOHOL AND DRUG TREATMENT CENTRE** participates in a National addictions treatment data base with other NNADAP and NYSAP Centre's across Canada. This system is known as "AMIS" (Addictions Management Information system). The system allows aggregate reporting of treatment data. No identifiers are used in any aggregate reporting. For the purpose of this form MIGISI ALCOHOL AND DRUG TREATMENT CENTRE and the other participating treatment providers are referred to as "Treatment Centre's".

With your permission, our participation in AMIS does three things:

1. It collects aggregate information to allow us to make better program improvement and treatment decisions for the populations we serve.
2. It provides a more secure electronic method for us to transfer confidential health information about you to other Treatment Centres who are treating you and request your information; and,
3. It allows other Treatment Centres to electronically disclose their confidential health information about you to us if we request your information for our treatment of you.

The purpose of this Consent is to obtain your permission for the sharing of a limited summary of your Treatment record between Treatment Centre's belonging to AMIS who may be involved with your treatment. The limited summary of your NNADAP/NYSAP treatment record will include (as applicable) the following components:

- Demographic Information including name, date of birth, SIN, Treaty Number and previous treatment episodes

With your consent we, as an AMIS participant, will deliver the limited summary of your treatment record which will store it electronically to another AMIS participant should you request future treatment. AMIS's record about you will be updated as we and other Treatment Centres, always with your consent, send additional information from later visits.

Your health information is private and confidential and is protected by law. These laws relate to your health information generally, as well as mental and behavioral health information and alcohol and drug abuse treatment information. AMIS Treatment centres are bound by these laws and various treatment centre accreditation standards related to protecting privacy.

### **CONSENT TO DISCLOSE CONFIDENTIAL PROTECTED HEALTH INFORMATION**

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

Date of Birth: \_\_\_\_\_

I consent to the collection and limited disclosure of a limited summary of my treatment record which includes:

Demographic Information including name, date of birth, and Treaty number

I consent to the following actions:

- MIGISI TREATMENT CENTRE may store my treatment information in the AMIS data base
- MIGISI TREATMENT CENTRE may disclose a limited summary of my treatment record through AMIS to any other AMIS Participant which requests such information in order to treat me and has my consent
- MIGISI TREATMENT CENTRE may incorporate the limited summary of my treatment record it receives through AMIS into TREATMENT CENTRE own files.

***Client Rights***

I understand that the law gives me the following rights:

- I may refuse to sign this Consent.
- I understand that my refusal to sign this Consent will not prevent me from receiving addictions care
- I may revoke this Consent. I understand that I may revoke this Consent in writing at any time except to the extent that and AMIS Participant has already relied on this form.

Expiration Date: I understand that unless revoked sooner, this Consent expires in 18 months from the date I signed it

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

Client/Guardian Signature: \_\_\_\_\_

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