MUSHKEGOWUK HEALTH

MUSHKEGOWUK COUNCIL ᐅᒪᐢᑫᑯ ᐅᑭᒪᐧᐃᐣ

MUSHKEGOWUK HEALTH

ASKIKAN – LAND BASED

11 Elm St. North
Timmins, ON P4N 6A3
P: 705.269.6662
F: 1.888.777.5708
E: landbase@mushkegowuk.ca

DISCLOSURE

The information in this application is ***confidential*** unless you provide written consent for us to share it or unless you pose a risk to yourself or someone else.

The application helps us understand your needs to best determine how we can assist with your path to wellness. Please take the time to complete the application to the best of your ability; the more information you provide, the better. You can fill it in yourself, have someone you know, and trust help you, or call us at the number below to schedule a time to complete it together. There are some sensitive topics, so having a support person with you is recommended.

If you choose not to attend, OR if you develop a sore throat, runny nose, cough, fever or aches a few days before your scheduled land base date, please notify the Land Based Program using the contact information below within ***48 hours*** to allow for the waitlisted participants to attend. If you develop symptoms of cough or cold you will be rescheduled to the next intake date.

If you are on the waitlist, you will be notified within ***24 hours*** of the next upcoming session date.

Medical Considerations: We are not medically equipped to accommodate individuals on Methadone, Suboxone, Narcotics, Ativan, or any Anti-Psychotic medications.

If you are prescribed any diabetic/insulin and supplies, epi-pens, or allergy medications, please bring these with you to site.

CONTACT INFORMATION:

Mushkegowuk Health
Askikan – Land Based Detox and Healing Program
11 Elm St. North
Timmins, ON P4N 6A3
P: 705.269.6662
F: 1.888.777.5708
E: landbase@mushkegowuk.ca

LAND BASED DETOX AND HEALING INTAKE FORM

DATE:		
A. CLIENT INFORMATION		
First Name:	Last Name:	
Preferred Name (if different from given name):		
Date of Birth: (mm/dd/yyyy)	Gender: ☐ M ☐ F ☐ Other:	
Status Card Number:	First Nation:	
Health Card Number and Version Code:		
Email Address:		
Cell Phone:	Can we leave a message here? ☐ Yes ☐ No	
Home Phone:	Can we leave a message here? ☐ Yes ☐ No	
Office Phone:	Can we leave a message here? ☐ Yes ☐ No	
Address:		
City:	Postal Code:	Province:
Language Spoken:	Language Understood:	
B. EMERGENCY CONTACT INFORMATION **to be contacted in the event of an emergency (ex. Hospitalization)*		
1. Full Name:		
Contact Number:	Relationship:	
2. Full Name		
Contact Number:	Relationship:	

Mushkegowuk Health, 11 Elm Street North, Timmins, ON P4N 6A3
Ph: 705-269-6662, Fax: 1-888-777-5708 E: landbase@mushkegowuk.ca

C. SUPPORT SERVICES

How many positive supports do you have in your life (including professionals)?

☐ None ☐ 1-3 people ☐ 4-6 people ☐ 7 or more

Family/Supports: *(collected for after-care and care planning purposes)*

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Care Providers

(collected for intake and after-care / care planning purposes)

Doctor/Nurse Practitioner:

Name: _____
Facility: _____
Address: _____
Phone Number: _____

Consent to Contact: ☐ Yes ☐ No

Probation/Parole:

Name: _____
Phone Number: _____
Email: _____

Court ordered attendance: ☐ Yes ☐ No
Consent to Contact: ☐ Yes ☐ No

Child Welfare Worker & Agency:

Name: _____
Agency: _____
Phone Number: _____
Email: _____

Is treatment part of your service plan? ☐ Yes ☐ No
Consent to Contact: ☐ Yes ☐ No

Counsellor/Other:

Name: _____
Facility: _____
Address: _____
Phone Number: _____

Consent to Contact: ☐ Yes ☐ No

D. MEDICAL HISTORY

List any diagnosed medical conditions (i.e., Diabetes, Hypertension, etc.)

Diagnosis:	Date Diagnosed:

Do you have any allergies?
(Drug and Non-Drug Related)

Do you require an epi-pen or allergy medication for reactions?
(If yes, please ensure you bring with you to site.)

Have you tested positive for Hepatitis B, C or HIV?
If yes, when?

MEDICATIONS:

Please list any prescription, non-prescription or herbal/natural medications you are currently taking. You may attach a photocopy if needed.

Name	Dose	Frequency	Route (ie., mouth, injections, etc.

*****Please bring ALL your medications with you, including any epi-pens, diabetic supplies and insulin.*****

Are you currently on Methadone, Suboxone or Sublocade? *If yes, please fill complete the boxes below.*

Drug:	Dose:	Frequency:	Route:	Duration:

E. SOCIAL

Education

Level of Education:

- ☐ Elementary
- ☐ High school
- ☐ College
- ☐ University
- ☐ Other: _____

Employment

Are you Employed? ☐ Yes ☐ No

- ☐ Full time
- ☐ Part time
- ☐ Seasonal
- ☐ Casual

Income

Source of Income:

- ☐ Employment
- ☐ Employment Insurance
- ☐ Workers Safety Insurance Plan (WSIB)
- ☐ Old Age Pension
- ☐ Canadian Pension Plan
- ☐ Social Assistance
- ☐ Other: _____

Do you have a criminal records? ☐ Yes ☐ No

Current Charges: _____

Court Date:

Living Arrangements, please explain: *(own, renting, living with family, etc.)*

_____

Have you or any of your family members attended residential school? ☐ Yes ☐ No

Were you, your parents or granparents involved in the Child Welfare System? ☐ Yes ☐ No

Do you feel connected to your culture? ☐ Yes ☐ No

Have you practiced specific cultural practices? ☐ Yes ☐ No

If yes, explain: _____

F. MENTAL HEALTH

People who are seeking services often struggle with mental health and learning differences. To plan for your success, let us know your history of mental health and learning differences, and check the box that best describes the impact of issue.

(X) for No or leave blank , (✓) for Yes	Do you experience	Formally diagnosed	Age it started	Impact: Minor	Moderate	Major
Anxiety	☐	☐		☐	☐	☐
ADD/ADHD	☐	☐		☐	☐	☐
Bipolar Disorder	☐	☐		☐	☐	☐
Depression	☐	☐		☐	☐	☐
Eating Disorder	☐	☐		☐	☐	☐
Grief	☐	☐		☐	☐	☐
Learning Disability	☐	☐		☐	☐	☐
OCD	☐	☐		☐	☐	☐
PTSD	☐	☐		☐	☐	☐
Psychosis	☐	☐		☐	☐	☐
Schizophrenia	☐	☐		☐	☐	☐
Other:	☐	☐		☐	☐	☐

G. FOUR SPHERES ASSESSMENT

Please rate the categories below by putting a (✓) checkmark in the box.	Very Poor	Poor	OK	Good	Excellent
Physical Health	☐	☐	☐	☐	☐
Emotional Wellness	☐	☐	☐	☐	☐
Mental Wellness	☐	☐	☐	☐	☐
Spiritual Wellness	☐	☐	☐	☐	☐

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when?

H. SUBSTANCE INVOLVEMENT				
Substance	Checkmark (✓) if Yes	Age started or duration used:	Last used:	For Nurse:
Stimulants *(increases energy and alertness)*				
1. Cocaine (powder or crack)	☐			
2. Methamphetamines (meth)	☐			
3. Amphetamines (adderall, crystal meth (jib), speed, uppers, bennies)	☐			
Depressants *(slow down CNS)*				
1. Opioids *(morphine, oxy, fentanyl, dilaudid, percocet, hydrocodone, codeine)*	☐			
2. Heroin	☐			
3. Benzodiazaepines *(valium, Xanax)*	☐			
Hallucinogens *(alter perception of reality)*				
1. LSD (acid)	☐			
2. Psilocybin *(magic mushrooms)*	☐			
3. PCP (angel dust)	☐			
Dissociatives *(cause detachment from reality)*				
1. Ketamine *(Special K)*	☐			
2. DXM *(some cough medicine)*	☐			
Cannabis/Marijuana/THC	☐			
Designer/Synthetic Drugs *(lab-made, unpredictable effects)*				
1. MDMA *(Ecstasy, Molly)*	☐			
2. Synthetic cannabinoids	☐			
3. Bath salts	☐			
Tranquilizers *(2 types)*				
1. Benzodiazepines *(valium, Ativan, clonazepam)*	☐			
2. Barbiturates *(phenobarbital-phennies, downers, sleepers)*	☐			
Tobacco	☐			
Alcohol	☐			
Solvent Inhalants *(gas, glue, paint thinner)*	☐			
Other:	☐			
Other:	☐			
Which substance(s) do you use the most?				
Which is your substance of choice (if you had access?)				

Are you interested in attending treatment programs? ☐ Yes ☐ No	
Are you interested in an Aftercare and/or Relapse Prevention program? ☐ Yes ☐ No	
SUBMISSION:	
Applicant Name:	
Signature:	Date:

Please review your application and ensure that this package is filled out to the best of your ability. If you require travel, you MUST include your 10-digit Status Number. If there are any changes in your contact information, please reach out to us as soon as possible so we can update your profile.

How to Submit your Application:

1. Fill and Sign the *"Consent Collection, Use and Disclosure of Personal Health Information"* (which can be found on our website: www.mushkegowukhealth.com
2. Ensure Land-Base application is completed, dated and signed.
3. Submit via fax, email or in-person to the attention of the Land Base Detox and Healing Program

Fax: *1-888-777-5708*
Email: *landbase@mushkegowuk.ca*
In-Person: *11 Elm St. North, Timmins, ON P4N 6A3*