**Transformations Program**

**Preliminary Intake Assessment Form**

**9611 102 Ave, Edmonton, AlbertaT5H 0E5**

**Main line: 780-217-7248**

**Message line: 780-429-4274 ext. 238**

**Send completed form to:**

Fax: 780-426-5392

Email: [Terri-rae.mateyko@salvationarmy.ca](mailto:Terri-rae.mateyko@salvationarmy.ca)

This form is to be completed by the client or a referral worker on the client’s behalf.

The medical assessment must be completed **by a physician** and included in this package.

PLEASE NOTE: **ALL SECTIONS MUST BE COMPLETED**. INCOMPLETE APPLICATIONS WILL BE Invalid.

This is a preliminary intake assessment; **not an intake package**. Upon receipt of this assessment, the intake team will assess this application and a team member will contact you or your referral worker. This is the first step in the intake process.

1. Complete this Preliminary intake package. *This is an intensive live in program*. Call with any questions.
2. Send completed package to Transformations via: Email – Program Navigator: [Terri-rae.mateyko@salvationarmy.ca](mailto:Terri-rae.mateyko@salvationarmy.ca)

Fax: 780-426-5392. or [echo.info@salvationarmy.ca](mailto:echo.info@salvationarmy.ca) Type “Transformations” in the subject line. Or by mail.

1. Receive a step 2 acceptance letter via mail or email or a telephone call and perform a telephone or virtual interview. \*You may be placed on a wait list.

* **If you do not have a means for us to contact you; please contact us 7 days after submitting your application**

1. Receive an intake date. Please arrive by 8:30 am on the date given.

Referred by:

* Self
* Remand/Justice (pre-medical not required; will be required in pretreatment)
* Alberta Health worker
* Social worker
* Immigration Service
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake Date: (D/M/Y) / /

Accepted/Declined-reason:

Confirmed with client Date: (D/M/Y) / /

Received Date: (D/M/Y) / /

**Treatment Centre Use Only:**

**Admission Criteria:**

The criteria for acceptance in the Transformations Program are as follows:

* Male - minimum age of 18 years.
* Substance abuse free for a minimum of 10 days as verified by physician, hospital, or detox centre.
* Medically and psychologically stable and requires no medical appliances such as IV’s, oxygen, wheelchair, walker. Clients must be fully ambulatory including ability to navigate stairs unassisted.

The Salvation Army does not discriminate based on any disability. These restrictions are predicated upon the structure of the facility which has no elevators, and upon the capacity of staff that are not qualified to care for persons with complex medical issues.

* If there is a documented mental health disorder the client must be stable.
* All legal, medical, employment and relationship services must be dealt with prior to intake; your full attention will be needed in this program.
* If the client has a health problem that requires medication he must be willing to abide by the Medication Storage Program.
* Clients admitted to the Transformations Program will provide urine samples.
* Can care for own personal hygiene, able to participate in housekeeping duties.
* Has an intent to complete treatment for substance abuse and alcohol/drug addiction.
* Will participate in the smoking cessation program.
* Willing to abide by the program philosophy, polices, schedules, and rules of the program, and willing to participate

in all program components which include counseling, group work, class work, homework, spiritual care, physical activity, service opportunities (chores), care of client area, and all relevant activities scheduled by Transformations Program staff.

# PART 1 – CLIENT INFORMATION

Complete the following in the spaces provided. If any information is not applicable indicate as NA, unknown as UNK and unavailable as UNA. Please mark all questions.

# General Information

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: |  | | | First Name: |  | | | Nickname (or other name known by): | | |  |
| Date of Birth: |  |  |  | Age: | Gender:  Male  Female | | Provincial Health Card Number: | | | | |
| D M Y | | |
| Address: |  | | | | | | | | | | |
| Telephone: | Home: | | | | | Cell: | | | If you do not have a phone how can we contact you : | | |
| Language(s): | Spoken: | | | | | Understood: | | | Preferred: | | |
| Status? |  Yes  No | | | Band Name: | |  | | Treaty #:10 digit. | |  | |
| Emergency Contact: |  | | | Telephone: | |  | | Relationship: | |  | |
| Person who my belongings can be released to : | Name: Phone:  Same as above. | | | | | | | | | | |
| Education Status: |  | | | | | Last grade/educational program completed: | | | | | |
| Literacy Level \*\* | Grade 9 is required | | | | | | | | | | |

## RELATIONSHIPS

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Marital Status: |  Single |  Married | |  Common-Law | | |  Widowed | |  Separated |  Divorced | |
| If prescriptions or ambulance are required; how will it be paid for?  Alberta works AISH Blue Cross Health Canada (INAC) Other: | | | | | | | | | | | |
| Child/Dependent’s Name | | | Gender: | | | Age | | Relationship | | | |
|  | | |  Male  Female | | |  | |  | | | |
|  | | |  Male  Female | | |  | |  | | | |
| Are you adopted/Spent time in foster care | | |  Yes  No | | |  | |  | | | |
| Do you have any spiritual/ religious beliefs? | | |  Yes  No | | |  | |  | | | |
| Family members; substance or mental health struggles. | | | | | | | | | | | Comments:   Yes  No |
| Supportive people in my life: | | | | | | | | | | |  |
| |  | | --- | | **EARLY EXIT PLAN** | | The following will be put in place if I leave treatment early. I understand that as I continue treatment, the  program will assist me to develop a more complete transition plan to ensure my continued support and  recovery when returning home. It is understood that if I leave the program on short notice or if I do not arrive  for my scheduled intake, my referral liaison and my emergency contact will be notified immediately. | | Client Name: | | Key Community Contact For Transition Plan (Name/Relationship): | | Phone: Email: | | Emergency Contact and/or Next of Kin (Name/Relationship) | | Phone: Email: | | Community/Health Authority Contact (Name/Agency): | | Phone: Email: | | **LEGAL INFORMATION** | | | | | | | | | | | |  |
| Has client been court ordered to attend treatment?   Yes  No | | | | | Probation Order attached?   Yes  No | | | | | | |
| Is the client under any of the following legal conditions?   Bail  Parole  Temporary Absence Order  House arrest/needs supervision for outings   Other (provide details, dates, etc.)  Is on a registry  **\*\* If currently in Remand- Please provide a way to contact client.**  Contact for Legal issues: Role Phone: Email: | | | | | | | | | | | |

**TREATMENT HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Has client participated in a substance misuse and/or mental health program?  Yes  No | | | | | | |
| If yes, describe program(s): | | | | | | |
| Is client currently prescribed: | | | | | | |
| Methadone  Yes  No \*not permitted | | Suboxone  Yes  No \*not permitted- Please review list of medications not permitted on last page | | | | |
|  | | | | | | |
|  | | | | | | |
| Has client participated in a residential treatment program before?   Yes  No | | | | Longest term of sobriety: | | |
| How did you maintain your sobriety? | | | | | | |
| If yes, please provide information on previous treatment experiences: | | | | | | |
| **Year** | **Treatment Centre** | | **Type of Addiction** | | **Completed** | **Comments** |
|  |  | |  | |  Yes  No |  |
|  |  | |  | |  Yes  No |  |
| Describe client’s reason(s) for currently requesting treatment: | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
| The most important “goal for me right now” is? | | | | | | |
|  | | | | | | |

* 1. **Substance(s) Used**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SUBSTANCE**  Circle specific substance(s) or print name | **Pattern & Frequency of Use**  In last 6 months: | **Method of Use**  N = nasal/snort O = oral/swallow IV = inject  IS = inhale/smoke | **Average Amount Used**  In a 24-hour period) | **Length of Time Used**  In days, months, years | **Date Last Used**  Include time if known |
|  | Occasional, Daily, Weekly, Monthly, Binge, Other |  |  |  |  |
| **Alcohol**: E.g. beer, wine, coolers, liquor, homebrew, Lysol®, hairspray, mouthwash, aftershave, etc. |  |  |  |  |  |
| **Marijuana**: E.g., pot, hash, hash oil, etc. |  |  |  |  |  |
| **Cocaine**: E.g. Crack, powder |  |  |  |  |  |
| **Inhalants/Solvents**: E.g. Lacquer, glue, paint thinner, gasoline, aerosol sprays, amyl nitrate, etc. |  |  |  |  |  |
| **Club Drugs**: E.g. Ecstasy (MDMA), GHB, Rohypnol, Ketamine, etc. |  |  |  |  |  |
| **Hallucinogens**: E.g. Psilocybin mushrooms, LSD, Peyote, PCP (Angel Dust), Mescaline, DMT |  |  |  |  |  |
| **Amphetamines**: E.g. Crystal meth, speed |  |  |  |  |  |
| **Illicit Street Opiates**: E.g. Heroin, Opium |  |  |  |  |  |
| **Fentanyl** Illicit Fentanyl or prescription, e.g. Duragesic®, Sublimaze®, Actiq® |  |  |  |  |  |
| **Prescription Opioids**: E.g. Codeine (T-2s, T- 3s,) Oxycodone (Percodan®, Percocet®), Hydrocodone (Lortab®, Lorcet®) Dilaudid®, Darvon®, Morphine, Demerol®, etc. |  |  |  |  |  |
| **Prescription Sedatives, Tranquilizers, Barbiturates, Benzodiazepines** E.g.  Valium®, Ativan®, Serax®, Rivotril®, Halcion®,  Librium®, Xanax®, Mogodon®, Nembutal®, Luminal®, Ambien®, etc. |  |  |  |  |  |
| **Prescription Stimulants**: E.g. Ritalin®, Dexedrine®, Adderall®, Concerta®, etc. |  |  |  |  |  |
| **Gabapentin** (Neuronton®) |  |  |  |  |  |
| **Over the Counter Drugs**: E.g. Codeine (T- 1s), Gravol®, Cough Syrup with Dextramethorphan (DXM) etc. |  |  |  |  |  |
| **Anabolic Steroids** |  |  |  |  |  |

Substance(s) of choice: 1. 2. 3.

Substance you are seeking treatment for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Withdrawal Affects

Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptom** | | | **Comments** |
| Blackouts |  Yes   No |  Not applicable   Unknown |  |
| Hallucinations |  Yes   No |  Not applicable   Unknown |  |
| Nausea/vomiting |  Yes   No |  Not applicable   Unknown |  |
| Seizures |  Yes   No |  Not applicable   Unknown |  |
| Shakes |  Yes   No |  Not applicable   Unknown |  |
| Delirium Tremens (DTs) |  Yes   No |  Not applicable   Unknown |  |
| Violence |  Yes   No |  Not applicable   Unknown |  |
| **Days substance free:** | |  |  |  | | --- | --- | --- | | Did you attend a detox? |  Yes   No |  Not applicable   Unknown | |  Yes   No | **\*\* 7 verifiable days needed for intake; test required on intake.** |

# Process/Behavioral/Emotional Struggles

Has client experienced struggles with any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| **Process/Behavioral/Emotional Struggles** | | | **Comments** |
| Gambling (slots, cards, Keno, bingo etc.) |  Yes   No |  Not applicable   Unknown |  |
| Eating (obesity, anorexia, bulimia, etc.) |  Yes   No |  Not applicable   Unknown |  |
| Sex (promiscuity, etc.) |  Yes   No |  Not applicable   Unknown |  |
| Internet, texting, social media, phone. |  Yes   No |  Not applicable   Unknown | \*\* **Please note no social networking, cell phones, internet connected devices will be permitted for the duration of the program**. |
| Grief/loss/ |  Yes   No |  | Comments: |

# Mental Health

Provide the following information about the client’s mental health status:

|  |  |  |  |
| --- | --- | --- | --- |
| **Mental Illness** | | | **Description** |
| Been diagnosed with mental illness(es) |  Yes   No |  Unknown | If yes, is medical documentation attached?  Yes  No  Not applicable |
| Currently being treated for mental illness(es) |  Yes   No |  Not applicable   Unknown | If yes, what treatment is being provided and by whom? |
| Currently on psychiatric medication |  Yes   No |  Not applicable   Unknown | If yes, describe medication. |
| Taking medication consistently |  Yes   No |  Not applicable   Unknown | Please describe. |
| Previous suicide attempts? |  Yes   No |  Not applicable   Unknown | If yes, when? Comments. |
| Hospitalized for suicide attempts |  Yes   No |  Not applicable   Unknown | If yes, when? Comments. |
| Currently suicidal |  Yes   No |  Unknown | Comments: |

# Other Issues/Needs

Provide information about other client issues and needs:

|  |
| --- |
| Describe client’s cultural and/or spiritual beliefs and practices that we need to be aware of. |
| Describe other significant issues we need to be aware of. (Reading, writing, hearing, vision, ability to sit or stand for periods, has been recently hospitalized, chronic or brain injury, dysregulation of emotions) |
| Currently:   * self-mutilation aggressive behaviors violent temper depressed mood * poor grooming/hygiene poor concentration sleep disturbance * hyperactivity paranoid ideation dissociative states mood swings * delusions hallucinations generalized anxiety panic attacks * hopelessness phobias social isolation worthlessness * other (specify)   Comments: |

# Application Checklist

|  |  |
| --- | --- |
| Completed and stamped Medical exam by Physician |  Yes  No |
| Reviewed my medications with Doctor for suitability for program |  Yes  No |
| Provided copies of any legal orders or probation requirements |  Yes  No |
| Confirmation of funding |  Yes  No |
| Completed all questions with an answer or N/A |  Yes  No |
| Completed Preliminary Assessment package sent to Transformations instructions on front/Keep copy for yourself |  Yes  No |
| Confirmation interview and intake date received |  Yes  No |
| Verifiable clean time of 7 days upon intake date |  Yes  No |
| Read, meet understand and agree to the admission criteria. |  Yes  No |
| Completed all outside appointments and employment or relationship commitments |  Yes  No |
| Client understands there is an recommendation of completion aftercare counselling sessions upon completion of residential treatment. |  Yes  No |
| Client has been informed about the following personal items needed on entering treatment:   * 7-10 Days of substance free time (verifiable) * Toiletries (toothbrush, toothpaste, shampoo, deodorant, etc.)Scent free environment * Bathing suit and shorts * Warm clothing (boots, coat, hat, gloves, etc.) * 2 pairs of running shoes for indoor/outdoor activities * Towel and facecloths * Pajamas and slippers * Personal items * Medications (All non-prescription and physician prescribed medication MUST be handed in to intake worker upon arrival and must be in SEALED, ORIGINAL PACKAGING) **\*\* please review list, some are not permitted\*\*** * Tobacco/nicotine replacement products * Money * Valid identification card * Alarm clock   Provincial health card(s) or photocopy of health card | Not Permitted:   Cell phones/social networking/internet   Ball caps/ head gear  Methadone/  /Suboxone  Protein powder supplements |

**Pretreatment Letter of Introduction**

Please write a one page letter: Why you have chosen to enter the Transformations Addictions and Recovery Program:

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

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# PART 2 – REFERRAL Worker Information or check box if self-referral or no worker and skip this section

# 

Referral Worker Name: Title:

Agency: Telephone:

Fax: Email:

Address:

Has the client completed four pre-treatment appointments?  Yes  No Please provide dates of completed pre-treatment appointments (D/M/Y):

1. 2. 3. 4.

Will you continue to see the client once he/she has completed treatment?  Yes  No If no, please explain:

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

|  |  |
| --- | --- |
| **Name/Resource** | **Description of Support** |
|  |  |
|  |  |
|  |  |
|  |  |

Briefly summarize all assessment processes completed with the client (e.g. CAGE MAST, DAST, Treatment Readiness, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, social, psychological, spiritual, and emotional). Include scoring and interpretations. Attach a separate sheet if necessary or the assessment summary from your client file.

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.

## Referral Checklist

Please initial which applicable items have been completed. Check off any items attached to this application:

|  |  |  |
| --- | --- | --- |
| **Item** | **Attached** | **Initials** |
| Psychiatric evaluations |  |  |
| Probation order |  |  |
| Current Medical Assessment form |  |  |
| Assessment Summary |  |  |
| Substance Abuse Profile |  |  |

Please initial each item that has been completed:

|  |  |
| --- | --- |
| **Item** | **Initials** |
| 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)

**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. I understand failure to adhere or dishonest answers may result in my not being accepted on my intake day. An intake urine screen and random screenings are part of the program; positive result for tested substances can result in being released from the program or being denied intake. I understand this is an intensive residential program, with guidelines and modules; required for my successful completion. I understand this is a 4 month program, with a 14 day pretreatment session. I understand counselling and therapeutic interventions are part of this program. I understand that smoking cessation is part of the program. I understand social networking and cell phones are not permitted. I understand my full participation and attendance to all components of the program is necessary.*

Client Signature Date (D/M/Y)

Referral Signature Date (D/M/Y)

|  |  |
| --- | --- |
| **WAIVER TO RELEASE INFORMATION** | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| *Print Name* |  |
| Authorize The Salvation Army to obtain or release information contained in this Intake Application. The purpose of sharing information with other health professionals, agencies, or institutions involved in the Assessment/Placement/Treatment process will be for the continuity of my care**.**   |  |  | | --- | --- | | Applicant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | *yyyy.mm.dd* | | | Witness/Intake staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | *yyyy.mm.dd* | |   **Consent to Psychotherapeutic counselling.**  **I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client. I consent to participate in counseling and assessment. I understand confidential counselling records will be kept; I can request to see these records.**  Psychotherapy involves a degree of risk. You may experience uncomfortable emotions as you talk about the issues that are concerning you. Sometimes therapy involves talking about unpleasant aspects of your history. Psychotherapy is focused on facilitating change according to the goals you set.  **Counselling is part of the Transformations program.**  **Exceptions to Confidentiality:**   * The staff in the Salvation Army Transformations Program work as a team and have access to view “all” client files and case notes, including test results and your Counsellor’s case notes of your counseling sessions. Your counsellor may consult the team without your authorization.   • If there is evidence of clear and imminent danger of harm to self and/or others, a counsellor is legally required to report this information to persons responsible for ensuring safety.  • Counseling staff that learn of, or strongly suspect, child or elder abuse (physical or sexual) must report this information to the authorities.  • A court order may require a release of the information contained in your records and/or require a counsellor to testify in a court hearing. | |
| Applicant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *yyyy.mm.dd* | |
| Witness/Intake staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *yyyy.mm.dd* | |

# PART 3 – MEDICAL ASSESSMENT

*\*If you are coming from Justice or Remand, or unable to complete, please indicate why you are unable to complete – as we will still consider the application.*

**All clients must have this form completed by a physician.** Please note: **First Nations Inuit Health - Alberta Region - Non-Insured**

**Health Benefits covers** a **maximum of $60.25 for a medical assessment by physicians in Alberta.** The invoice has to include the client’s

Treaty number and confirmation that the invoice is a medical assessment.

Applicant’s name: Health Care Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treaty Number (10 digits) Are you the client’s regular physician?  Yes  No

## Medical History: (explain any ‘yes’ responses in Section B)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Diagnosed** | | **Tested** | | **Comments** | |
|  | **Yes** | **No** | **Yes** | **No** |  | |
| Central Nervous System Disorder |  |  |  |  |  | |
| Chronic bronchitis |  |  |  |  |  | |
| Asthma |  |  |  |  |  | |
| Heart problems  Current blood pressure |  |  |  |  |  | |
| Gastrointestinal problems |  |  |  |  |  | |
| Pancreatic problems |  |  |  |  |  | |
| Kidney or urinary problems |  |  |  |  |  | |
| Diabetes / hypoglycemia |  |  |  |  |  | |
| Epilepsy |  |  |  |  |  | |
| Tuberculosis |  |  |  |  |  | |
| Chronic pain |  |  |  |  |  | |
| Eating disorders |  |  |  |  |  | |
| Sleep disorders |  |  |  |  |  | |
| Brain injury : severity: |  |  |  |  |  | |
| Mood disorders (e.g., major depressive disorder) |  |  |  |  |  | |
| Psychotic disorders (e.g., schizophrenia) |  |  |  |  |  | |
| Personality Disorders |  |  |  |  |  | |
| Liver problems: Hepatitis B & C |  |  |  |  |  | |
| HIV/AIDS |  |  |  |  |  | |
| Sexually Transmitted Diseases |  |  |  |  |  | |
| Prior Psychiatric Treatment |  |  |  |  |  | |
| Allergies |  |  |  |  |  | Epipen required  |
| Emotional Regulation Issues |  |  |  |  |  | |

Any other medical problems not listed:

## Are there any specific problems that should be considered in the treatment of this applicant?

1. **Current Medications**

Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. Please note no mood altering medications (Print out list and attach) will be allowed in residential treatment unless prescribed and monitored by a psychiatrist for management of a mental illness. No opiate replacement/OAT's allowed.

|  |  |  |  |
| --- | --- | --- | --- |
| **DRUG NAME** | **DOSE/SCHEDULE** | **LENGTH OF TIME USED** | **CLINICAL INDICATION** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Reminder to physician**: For the applicant’s safety and wellness while in residential treatment, please arrange with his or her pharmacy for compliance with packaging of medication to take to treatment and prescribe sufficient quantities for duration of treatment. (4 months)

Is the applicant stabilized on medication?  Yes  No

In the past 6 months has the client been using the medication appropriately?  Yes  No If no, please explain:

Have you assessed the client’s ability to regulate emotions?  Yes  No

Physician’s Name: Telephone:

Date: Address:

PRAC ID: Fax:

Physician’s Signature: Date:

Physician’s Stamp:

The following are medications not permitted in the Transformations Program.

**Opioid Pain medications:**

Codeine & products containing Codeine (eg. Tylenol 3) Oxycodone(Percocet, OxyNeo)

Morphine (eg. Kadian) Meperidine (Demerol)

Fentanyl Tapentadol (Nucynta)

Hydromorphone (Dilaudid) Tramadol(Zytram, Ralivia, Tridural)

Pentazocaine (Talwin) Propoxyphene(Darvon)

And all others.

**Benzodiazepines:**

Alprazolam (Xanax) Bromazepam( Lectopam)

Lorazepam (Ativan) Oxazepam (Serax)

Temazepam (Restoril) Triazolam (Halcion)

Chlordiazepoxide (Librium) Clonazepam (Rivotril)

Clorazepate (Tranxene) Diazepam (Valium)

Flurazepam (Dalmane) Nitrazepam (Mogadon)

And all others

**Psychostimulants:**

Dextroamphetamine (Dexedrine) Amphetamine Mixed Salts (Adderall XR)

Lisdexamfetamine (Vyvanse) Methylphenidate (Ritalin, Biphentin, Concerta)

Modafinil (Alertec)

And all others

**Miscellaneous:**

Varenicline (Champix) Nabilone (Cesamet)

Dronabinol (Marinol) Medical Marijuana

Zopliclone (Imovane) Opiate agonist Therapy (Suboxone)

Opiate replacements (Methodone, Methodose)

***What if I am on a restricted medication?*** We have 3 suggestions for restricted medications prior to admission:

1. Make a plan with your physician to taper off of the medication.
2. Request an alternative medication to the one on the restricted list.
3. In the event that a physician feels there is no alternate; a medical note may be written by them stating their case.

***This note must contain:***

1. What the medication is being used to treat
2. What the dose is
3. What is the duration of use
4. Statement that there is not alternate
5. What happens if the client is not on this medication
6. Statement that the physician believes this medication would contribute to the client successfully completing addictions treatment.