Please return completed applications to
**info@thecarterhouse.net**
Referrals must be completed by a service provider. Self-referrals will not be accepted.

# Application for Family Treatment
# The Carter House

## Referral check list

- ☑ Consent form signed.
- ☐ Applicant is a resident of Saskatchewan
- ☐ No children over the age of 12 have been included in the referral.
- ☐ Parent(s) have custody of children included in this application to attend family treatment.
- ☐ Parent(s) aware that they are fully responsible for the care of their children while attending treatment.
- ☐ Parent(s) with infants must provide infant formula, diapers and any other needed supplies.
- ☐ Parent(s) have completed the parent portion of the application.
- ☐ Parent(s) will need to have completed medical forms for all participants in the application prior to admission.
- ☐ All prescribed medications will be bubble packed and handed over to the medical team at time of admission for storage and administration.

| Referring Agency Information |
| --- |
| Date of Referral: |
| Referring Organization: |
| Person Referring |
| Phone Number |
| Email Address |
| Will you continue to support your client through and after completion of family treatment?<br>Yes ☐ No ☐ |

## Family Information

| Name (Parent A) Jenny Newman | DOB: | Phone# |
|---|---|---|
| PHN: | Relationship: | |
| Address: | | |
| Ethnicity: | Registered First Nations:<br>☐ Yes<br>☐ No | |
| Email: | | |
| Family Physician: | Phone number: | |
| **List all medications:** | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Emergency Contact** | | |
| **Phone:** | | |
| **Address:** | | |

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| | | |
|---|---|---|
| **Name (Parent B):** | DOB: | Phone# |
| PHN: | Relationship: | |
| Address: | | |
| Ethnicity: | Registered First Nations:<br>☐ Yes<br>☐ No | |
| Email: | | |
| Family Physician: | Phone number: | |
| **List all medications:** | | |
| | | |
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| | | |
| | | |
| **Emergency Contact** | | |
| **Phone:** | | |
| **Address:** | | |

| **Child 1 (Only complete for children who are attending family treatment)** | | |
|---|---|---|
| Name: | DOB: | Age: |
| PHN: | Gender: | |
| Registered as First Nations Yes ☐ No ☐ | | |
| School Name: | Grade: | |
| Any confirmed medical diagnosis/conditions or concerns? | | |
| Any documented learning, behavioral or cognitive diagnosis/conditions or concerns? | | |
| Family Physician: | Phone Number: | |
| **List all medications below:** | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Is child in Parent(s) custody?<br>☐ Yes<br>☐ No | | |

| Child abuse/neglect exposure (Click all that apply and provide detailed explanation below) | | |
|---|---|---|
| ☐ Physical Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Sexual Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Medical Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Emotional Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Physical Neglect | ☐ Suspected | ☐ Confirmed |

Detailed explanation:

| Child 2 (Only complete for children who are attending family treatment) | | |
|---|---|---|
| Name: | DOB: | Age: |
| PHN: | Gender: | |
| Registered as First Nations Yes ☐ No ☐ | | |
| School Name: | Grade: | |
| Any confirmed medical diagnosis/conditions or concerns? | | |

| Any documented learning, behavioral or cognitive diagnosis/conditions or concerns? | |
|---|---|
| Family Physician: | Phone Number: |
| **List all medications below:** | |
| | |
| | |
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| | |

Is child in Parent(s) custody?

- ☐ Yes
- ☐ No

**Child abuse/neglect exposure (Click all that apply and provide detailed explanation below)**

| | | |
|---|---|---|
| ☐ Physical Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Sexual Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Medical Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Emotional Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Physical Neglect | ☐ Suspected | ☐ Confirmed |

Detailed explanation:

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| Child 3 (Only complete for children who are attending family treatment) | | |
|---|---|---|
| Name: | DOB: | Age: |
| PHN: | Gender: | |
| Registered as First Nations Yes ☐ No ☐ | | |
| School Name: | Grade: | |
| Any confirmed medical diagnosis/conditions or concerns? | | |
| Any documented learning, behavioral or cognitive diagnosis/conditions or concerns? | | |
| Family Physician: | Phone Number: | |
| **List all medications below:** | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Is child in Parent(s) custody?<br>☐ Yes<br>☐ No | | |

| Child abuse/neglect exposure (Click all that apply and provide detailed explanation below) | | |
|---|---|---|
| ☐ Physical Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Sexual Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Medical Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Emotional Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Physical Neglect | ☐ Suspected | ☐ Confirmed |

Detailed explanation:

| Child 4 (Only complete for children who are attending family treatment) | | |
|---|---|---|
| Name: | DOB: | Age: |
| PHN: | Gender: | |
| Registered as First Nations Yes ☐ No ☐ | | |
| School Name: | Grade: | |
| Any confirmed medical diagnosis/conditions or concerns? | | |

| Any documented learning, behavioral or cognitive diagnosis/conditions or concerns? | |
|---|---|
| Family Physician: | Phone Number: |
| **List all medications below:** | |
| | |
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| | |

Is child in Parent(s) custody?

- ☐ Yes
- ☐ No

**Child abuse/neglect exposure (Click all that apply and provide detailed explanation below)**

| | | |
|---|---|---|
| ☐ Physical Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Sexual Abuse | ☐ Suspected | ☐ Confirmed |
| ☐ Medical Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Emotional Neglect | ☐ Suspected | ☐ Confirmed |
| ☐ Physical Neglect | ☐ Suspected | ☐ Confirmed |

Detailed explanation:

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| Substance Use Profile | | | | | |
|---|---|---|---|---|---|
| Type | Age of first use | Frequency | Amount | Method of use | Date last used |
| Alcohol | | | | | |
| Cannabis | | | | | |
| Cocaine | | | | | |
| Hallucinogen | | | | | |
| Barbiturate | | | | | |
| Amphetamine | | | | | |
| Heroin | | | | | |
| Opiate | | | | | |
| Inhalant | | | | | |
| Illicit Methadone | | | | | |
| Benzodiazepine | | | | | |
| Other prescription drugs | | | | | |

| **Have parents been successful in achieving sobriety prior to this application, if so when and for how long?** |
|---|
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|---|
| |
| **Has the parent(s) attended treatment before?** |
| |
| **What resources have the parent(s) accessed for support with addiction in the past if any?** |
| |

**Supporting Documentation – Completed items to be attached with referral**

- ☐ Medical letter supporting client is healthy to participate in the program
- ☐ Toxicology screen with 72 hours of admission
- ☐ Psychological Assessments
- ☐ Educational Reports for all children

**CONSENT FOR RELEASE OF INFORMATION**

I, and I, agree to enter the programs and services offered through The Carter House Family treatment Centre. I am aware that The Carter House Family Treatment Program is designed to support me/us in meeting my/ our goals of completing family treatment for substance use. This program works collaboratively between programs, physicians, nurses, case managers, social workers, and other support services.

To assist you in receiving effective care, we would like your permission to collect, use and disclose your personal health information or personal information between the referring organization, and members of your support team. The team consists of professionals representing the following agencies:

- Ministry of Social Services
- Westside Community Clinic
- Jordon's Principal
- Saskatchewan Health Authority
- Public School System
- Catholic School System

Staff members of The Carter House Family Treatment Centre will discuss your case to determine if Family Treatment is appropriate for you. To determine if this program is right for you, The Carter House will collaborate on issues related to your various care needs. Specific information discussed may include you and your children's physical and mental health, substance use, support in the community, relationships, housing, and income. We require this information to determine if the assessment suites are the right program for you.

I agree to release my Information as follows (please check one of the following options):

☐ I give my consent to share my Information with all the members of The Carter House Family Treatment Centre

☐ I give my consent to share my Information with the following organizations:

- ☐ Ministry of Social Services
- ☐ Public and Catholic School Systems
- ☐ Westside Community Clinic
- ☐ Saskatchewan Health Authority

I understand that my access to care from these specific programs will not be affected by my decision to allow my Information to be shared or not.

This consent remains in effect for one year from date of signature; I understand that I can change my mind at any time, regarding who I allow my information to be shared with. I understand that if I change my mind, the information previously shared is not affected.

I,____________________ and I,___________________ (Printed Name), hereby provide authorization to the collection, use and disclosure of information about myself to The Carter Family Treatment Centre.

______________________________ ___________________________ ___________

Signature Signature Date

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