The Carter House
A Family Treatment Centre

Application for Family Treatment

Referring Agency Information	
Date of referral:Click or tap to enter a date.	
Referring Organization:Click or tap here to enter text.	
Person Referring:Click or tap here to enter text.	Phone #Click or tap here to enter text.
Email:Click or tap here to enter text.	
Will you continue to support your client through and after completion of family treatment? ☐Yes ☒No If no please explain: Click or tap here to enter text.	

Referral Check List

☐ Consent form signed.
☐ All those on the application have a valid health card
☐ 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 supervision and care of their children while attending treatment.
☐ Parent(s) with infants must provide infant formula, diapers, stroller, wipes, soothers, baby food, wipes, cremes, bathing supplies, nail clippers and any other needed supplies.
☐ All those on the application will need to have completed medical forms prior to admission INCLUDING ALL Children coming with the parent to treatment or visiting with plan for reunification at the Centre.
☐ All prescriptions will be faxed to Westside Community Clinic (1528 20th St W) one week prior to admission date
☐ All prescribed medications will be bubble packed for storage and administration.
☐ Criminal record and vulnerable sector search completed and submitted for all Males over the age of 12
☐PARENTS AND THEIR CHILDREN MUST BE ACCOMPANIED BY A SERVICE PROVIDER FOR THE ADMISSION DATE AND TIME AND ARE EXPECTED TO STAY UNTIL THE FAMILY HAS COMPLETED THE INTAKE PROCCESS

Family Information		
Name (Parent A):Click or tap here to enter text.	DOB:Click or tap to enter a date.	Phone#Click or tap here to enter text.
HSN:Click or tap here to enter text.	Relationship:Click or tap here to enter text.	
Address:Click or tap here to enter text.		
Ethnicity:Click or tap here to enter text.	Registered as First Nations Yes☐ No☐	
Email:Click or tap here to enter text.	Band Name and Treaty Number Click or tap here to enter text.	

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Family Physician:Click or tap here to enter text.	Income source: Click or tap here to enter text.	
List all Medications:		
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
EMERGENCY CONTACT: Click or tap here to enter text.	Phone:Click or tap here to enter text.	Address:Click or tap here to enter text.
Name (Parent B): Click or tap here to enter text.	DOB:Click or tap to enter a date.	Phone#Click or tap here to enter text.
HSN:Click or tap here to enter text.	Relationship:Click or tap here to enter text.	
Address:Click or tap here to enter text.		
Ethnicity:Click or tap here to enter text.	Registered First Nations: Yes ☐ No ☐	
Email:Click or tap here to enter text.	Band Name and Treaty Number Click or tap here to enter text.	
Family Physician:Click or tap here to enter text.	Income source: Click or tap here to enter text.	
List all Medications (prescription and non-prescription):		
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
EMERGENCY CONTACT: Click or tap here to enter text.	Phone:Click or tap here to enter text.	Address:Click or tap here to enter text.
Child 1 (Only complete for children who are attending family treatment)		
IS CHILD CURRENTLY IN PARENTS CUSTUDY YES ☐ NO ☐ If No: Is reunification at treatment being requested Yes ☐ No☐		
Name:Click or tap here to enter text.	DOB:Click or tap to enter a date.	Age:Click or tap here to enter text.
HSN:Click or tap here to enter text.	Gender:Click or tap here to enter text.	
Registered as First Nations Yes ☐ No☒	Band Name and Status Number Click or tap here to enter text.	
School Name:Click or tap here to enter text.	Grade:Click or tap here to enter text.	

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Any confirmed medical diagnosis/conditions or concerns?
Click or tap here to enter text.

Any documented learning, behavioral or cognitive diagnosis/conditions or concerns?
Click or tap here to enter text.

Family PhysicianClick or tap here to enter text.	Phone Number: Click or tap here to enter text.

List all Medications (prescription and non-prescription):	
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

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: Click or tap here to enter text.

Child 2 (Only complete for children who are attending family treatment)

IS CHILD CURRENTLY IN PARENTS CUSTUDY YES ☐ NO ☐ If No: Is reunification at treatment being requested Yes ☐ No☐

Name:Click or tap here to enter text.	DOB:Click or tap to enter a date.	Age:Click or tap here to enter text.
HSN:Click or tap here to enter text.	Gender:Click or tap here to enter text.	
Registered as First Nations: Yes ☐ No ☐	Band Name and Treaty Number Click or tap here to enter text.	
School Name:Click or tap here to enter text.	Grade:Click or tap here to enter text.	

Any confirmed medical diagnosis/conditions or concerns?
Click or tap here to enter text.

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Any documented learning, behavioral or cognitive diagnosis/conditions or concerns? Click or tap here to enter text.	
Family PhysicianClick or tap here to enter text.	Phone Number: Click or tap here to enter text.
List all medications below:	
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

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: Click or tap here to enter text.

Child 3 (Only complete for children who are attending family treatment)

IS CHILD CURRENTLY IN PARENTS CUSTUDY YES ☐ NO ☐ If No: Is reunification at treatment being requested Yes ☐ No☐

Name:Click or tap here to enter text.	DOB:Click or tap to enter a date.	Age:Click or tap here to enter text.
HSN:Click or tap here to enter text.	Gender:Click or tap here to enter text.	
Registered as First Nations: Yes ☐ No☐	Band Name and Treaty Number Click or tap here to enter text.	
School Name:Click or tap here to enter text.	Grade:Click or tap here to enter text.	

Any confirmed medical diagnosis/conditions or concerns?
Click or tap here to enter text.

Any documented learning, behavioral or cognitive diagnosis/conditions or concerns?Click or tap here to enter text.

Family PhysicianClick or tap here to enter text.	Phone Number: Click or tap here to enter text.
List all Medications below (prescription and non-prescription):	
Click or tap here to enter text.	Click or tap here to enter text.

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Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

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

Provide details for any checked exposure:

Child 4 (Only complete for children who are attending family treatment)

IS CHILD CURRENTLY IN PARENTS CUSTUDY YES ☐ NO ☐ If No: Is reunification at treatment being requested Yes ☐ No☐

Name:Click or tap here to enter text.	DOB:Click or tap to enter a date.	Age:Click or tap here to enter text.
HSN:Click or tap here to enter text.	Gender:Click or tap here to enter text.	

Registered as First Nations Yes ☐ No☐	Band Name and Treaty Number Click or tap here to enter text.
School Name:Click or tap here to enter text.	Grade:Click or tap here to enter text.

Any confirmed medical diagnosis/conditions or concerns?
Click or tap here to enter text.

Any documented learning, behavioral or cognitive diagnosis/conditions or concerns?
Click or tap here to enter text.

Family PhysicianClick or tap here to enter text.	Phone Number: Click or tap here to enter text.

List all Medications below (prescription and non-prescription):

Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

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Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

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:
Click or tap here to enter text.

Detailed explanation:
Click or tap here to enter text.

Care taker risk factors: Please check the boxes of any applicable risk factors & provide an in-depth explanation below.

☐Substance Misuse	☐Homelessness	☐Ability to Protect their Child(ren)
☐Domestic Violence	☐Unstable Mental Health	☐Substance use related to Neglect
☐Sex Trade	☐Cognitive Impairment	☐Non-Substance use related Neglect
☐Criminal Charges	☐Gang Involvement	☐Historical MSS Involvement
☐Parenting Capacity	☐Children in Care	☐ Violence (historical or present)
☐History of Physical Abuse (Against child(ren))		☐History of Sexual Abuse (Against Child(ren))

Detailed explanation:
Click or tap here to enter text.

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Substance Use Profile					
Type	**Age of first use**	**Frequency**	**Amount**	**Method of use**	**Date last used**
Alcohol	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Cannabis	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Cocaine	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Hallucinogen	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Barbiturate	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Amphetamine	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Heroin	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Opiate	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Inhalant	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Illicit Methadone	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Benzodiazepine	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Other prescription drugs	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.

Have parents been successful in achieving sobriety prior to this application, if so when and for how long?

Click or tap here to enter text.

Has the parent(s) attended treatment before?

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Click or tap here to enter text.

What resources have the parent(s) accessed for support with addiction in the past if any?

Click or tap here to enter text.

Please provide your assessment of the family's treatment readiness and any potential barriers for successful completion of treatment?

Click or tap here to enter text.

Supporting Documentation – Completed items must attached with referral:

- ☐ Medical letter supporting parents and children to participate in the program
- ☐ Toxicology screen with 72 hours of admission
- ☐ Psychological Assessments
- ☐ Educational Reports for all children
- ☐ Criminal record and vulnerable sector search for males over the age of 13

☐☐☐☐

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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
Saskatchewan Health Authority	Catholic School System
Clinical Psychologist	Public 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
  - ❒ Clinical Psychologist

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