The Carter House
A Family Treatment Centre

Application for Family Treatment

Referring Agency Information	
Date of referral:	
Referring Organization:	
Person Referring:	Phone:
Email:	
Will you continue to support your client through and after completion of family treatment? ☐Yes ☐No If no please explain:	

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):	DOB:	Phone:
HSN:	Relationship:	
Address:		
Ethnicity:	Registered as First Nations Yes☐ No☐	
Email:	Band Name and Treaty Number	

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Family Physician:	Income source:	
List all Medications:		
EMERGENCY CONTACT:	Phone:	Address:
Name (Parent B):	DOB:	Phone:
HSN:	Relationship:	
Address:		
Ethnicity:	Registered First Nations: Yes ☐ No ☐	
Email:	Band Name and Treaty Number	
Family Physician:	Income source:	
List all Medications (prescription and non-prescription):		
EMERGENCY CONTACT:	Phone:	Address:
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:	DOB:	Age:
HSN:	Gender:	
Registered as First Nations Yes ☐ No ☐	Band Name and Status Number	
School Name:	Grade:	

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Any confirmed medical diagnosis/conditions or concerns?
Any documented learning, behavioral or cognitive diagnosis/conditions or concerns?

Family Physician:	Phone Number:

List all Medications (prescription and non-prescription):	

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:

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:	DOB:	Age:
HSN:	Gender:	
Registered as First Nations: Yes ☐ No ☐	Band Name and Treaty Number	
School Name:	Grade:	
Any confirmed medical diagnosis/conditions or concerns?		

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

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:

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:	DOB:	Age:
HSN:	Gender:	
Registered as First Nations: Yes ☐ No☐	Band Name and Treaty Number	
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 (prescription and non-prescription):		

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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

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:	DOB:	Age:
HSN:	Gender:	
Registered as First Nations Yes ☐ No☐	Band Name and Treaty Number	
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 (prescription and non-prescription):

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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:

Detailed explanation:

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:

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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?					
Has the parent(s) attended treatment before?					

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

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