Sunrise Healing Lodge
1231 - 34th Avenue N.E., Calgary, AB T2E 6N4
(P) 403-261-7921 (F) 403-261-7945 Administration
(P) 403-269-5567 (F) 403-269-5578 Client Admissions
(E) admissions@nass.ca

Sunrise Healing Lodge Society
Application for Inpatient Treatment

Date:_____

Last Name:_____ First Name:_____

Address:_____

Phone Number:_____ Email: _____

Date of birth:_____ Age:_____

How do you identify?: Male ____ Female ____ Other _____

How did you hear about us? _____

Are you: ☐ Treaty/Status ☐ Non-Status ☐ Métis ☐ Inuit ☐ Other

Band Name: _____ Treaty # :_____

Are you a residential school survivor? YES _____ NO_____

AHC#:_____ SIN#:_____

Occupation:_____ Employer:_____

Marital Status:_____

Number of Children (Less than 18 years old) and ages: _____

Are you **mandated** by Child and Family Services to attend treatment: YES _____ NO _____

Are Child and Family Services involved with your family? _____

Next of kin or person(s) to be notified in case of emergency:

Name:_____ Phone Number:_____

Address:_____

Relationship to Applicant:_____

Primary Addiction: _____

When did you start and how often do you use/drink/gamble etc? _____

_____

Secondary Addiction: _____

When did you start and how often do you use/drink/gamble etc? _____

_____

Please provide any details regarding previous treatment experience for

Alcohol/Drug/Gambling dependency:

_____

_____

1) Please indicate what you are hoping to achieve through attending our program and

2) Please detail your level of commitment to your recovery:

_____

_____

Have you ever been **diagnosed** with a Mental Health concern (i.e., depression, anxiety, bipolar disorder, personality disorder, etc.) YES ____ No ____

If Yes, what?_____

Are you currently on any medications? If yes, please list name of medication(s):

_____

_____

Are you aware of any family member who is employed by Sunrise Healing Lodge or is currently a client? YES _____ NO_____

Is this your first visit to Sunrise: YES _____ NO _____

Are you currently feeling suicidal or have you had a recent suicide attempt?
YES _____ NO _____

- **Sunrise is NOT a medical facility and has NO medical staff on site. By initialing here the client acknowledges and understands the forgoing. Initial _____.**

Please describe your situation in the following areas:

1. Family Relationships:

_____

_____

_____

2. Employment (Regular type of work, employment status etc.)

_____

_____

_____

3. Social (groups, activities, friends, etc.)

_____

_____

_____

4. Legal/Past and Pending Charges/Upcoming Court Dates/Parole/Probation/Mandated to Treatment) – Please list ALL past and pending charges and court dates. <u>Disclosure of legal history and current charges is a REQUIREMENT to attend treatment:</u>

_____

_____

_____

5. Family Addictions History:

_____

_____

6. Financial (Source of income, debts. etc)

_____

_____

Do you have housing after treatment? YES _____ No _____

Applicant's Signature: _____

<u>Please note:</u> Sunrise Healing Lodge reserves the right to refuse admission to clients it deems inappropriate for its programs.

Medication Policy for Admissions

Sunrise reviews the medication requirements and medical needs of all potential clients prior to admission. Should Sunrise staff require additional information, potential clients must agree to sign a Release/Receipt of Information for their doctor, mental health professional, or others as necessary.

Under no circumstances are Sunrise clients permitted to take **opioids, opioid replacements, benzodiazepines, barbiturates/sedatives, gabapentin, cough/cold medications, sleeping aids or stimulants** while at Sunrise. Clients are not to **start** any mood-altering medication while in the care of Sunrise. Potential clients who take medication must be stable on this medication for a minimum of **4 weeks** prior to admission. ALL medications must be **prescribed** and deemed medically necessary (including vitamins).

Sunrise Healing Lodge does not have medical staff on site; therefore all potential clients must take care of their health and medication needs prior to admission to Sunrise.

Sunrise reserves the right to deny any potential client admission to the Inpatient or Outpatient programs based on medication or medical needs.

I, _____, of my own free will, without duress or undue influences
(Applicant's Name)
hereby give permission to Sunrise Healing Lodge Society to release/receive relevant, confidential information written or oral to - from **Blue Bottle Pharmacy** for the purpose of my application to attend treatment. This authorization shall legally remain in effect until cancelled by myself in writing or after **a period of 2 years** from the date this form is signed.

_____ _____

Applicant Signature Date

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Important Information for Clients
(Please keep for your information – Do not send back)

Appointments:

All legal, medical, employment, housing and child-care appointments must be dealt with prior to admission. Clients will not be allowed to attend outside appointments/court dates while in the Inpatient Program.

Financial Information

- Please ensure arrangements have been made for funding for treatment.
- If paying room and board fees personally, Sunrise will only accept money orders or certified cheques**.**
- If you are paying for your treatment please have a bank draft or money order made out to Sunrise Healing Lodge Society prior to admission.
- Room and Board fees are your responsibility. You can access funding through Alberta Works - if eligible. If you are being mandated to attend treatment please have your worker approve funding prior to admission in writing.
- Do not bring in large amounts of cash - only bring enough to get by (for bus tickets/tobacco). We will not hold money for clients and are not responsible.

Application:

Please ensure your application, including your medical assessment, is complete. After your application is sent in, allow 3 business days for processing. Once your application has been approved, we will give you a confirmation date. You are responsible to call the Admissions Coordinator 2 times a week to check in – you can leave a message. If you do not check in, your bed may be given to another client.

What to Bring to Treatment:

- Bus Pass or bus tickets (required to attend outside 12 Step meetings)
- Shampoo, Conditioner, Soap
- Deodorant and other Personal Hygiene/ Care Items
- Tooth brush and tooth paste

- Alarm clock
- Slippers, Moccasins, Clothes according to season
- Tobacco - Enough for two weeks minimum
- Phone cards for long distance phone calls.

Medications: Please see above Medication Policy Form

- **Please ensure all prescriptions have been filled and that there is enough for the duration of your treatment.**
- All medications must be approved by your doctor and Sunrise prior to admission. Medications must be in their original packaging with **original labels**.

Other Stuff:

- You must stop gambling and using drugs & alcohol a minimum of **3 days** before your admission. If you need help to stop using drugs &/or alcohol prior to your admission, let us know and we will help you with a referral.
- You are expected to attend community 12 Step meetings, please bring a bus pass/tickets.
- We reserve the right to perform random drug and alcohol tests.
- **You may not bring any items containing alcohol or acetone, cell phones or any electronic devices - Such items will be put in storage for the duration of the 10 week program.**
- No outside food (i.e. Candy, pop, etc.) is allowed into the agency. All outside food and drinks will be disposed of upon admission and after passes.
- No outside bedding or towels, Sunrise will supply all bedding and towels. No stuffed toys.
- If you must use your vehicle for transportation to Sunrise, please be aware that you will not be able to use it during the (10) weeks of your treatment. Keys must be handed in to staff.
- No couples, siblings, or immediate family members are permitted to attend any Sunrise programs at the same time.
- You will be expected to arrive at the agency at the time told to you by the Admissions Coordinator.
- You must call the Admissions Coordinator 2 times a week to check in and if you fail to do so your treatment date may be bumped or you may be taken off the list completely.
- You must be aware that you are responsible for return transportation if you are discharged from treatment or choose to leave the program early.
- Smoking is allowed only outside the centre in designated areas and during specific times.
- Treatment groups run 7 days a week. It is **mandatory** for you to attend all groups, including 12 Step meetings and Cultural activities.
- Open communication occurs between all counselors. Sunrise strictly upholds client confidentiality outside of the agency.
- Visiting hours are on Saturdays only. The hours are 1:00pm to 9:00pm for adults and 1:00pm to 6:00pm for children.
- Sunrise does not provide housing services to clients. You are welcome to look after your own housing needs for after treatment, on your Thursday or Saturday pass.

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Confidential Inpatient Treatment Medical Form

It is a requirement of Sunrise Healing Lodge Society that any client seeking admission to this facility must present a recent medical examination. This form should be filled out by a Doctor/RN and be included with the client's application for admission.

Applicant's Name:_____
Date of Birth: _____**Alberta Health Care Number:** _____

Client's Consent to Release Information:

I, _____ (client's name) hereby consent to the release of my medical assessment contained in this questionnaire to Sunrise Healing Lodge Society. I also give permission for Sunrise and staff to contact the below medical professional should further medical information be required for my admission to the Sunrise program.

Client or Applicant's Signature: _____
Date: _____

Doctor/RN Name: _____ **Phone Number:**_____
Address:_____

Are you the applicant's regular Doctor: YES ☐ NO ☐

Certain medical conditions may restrict the client's participation in the treatment program. Please indicate whether this applicant has a history of any of the following:			
Cancer		**Sexually Transmitted Disease**	
Epilepsy		**Heart Disease**	
Diabetes		**Tuberculosis**	
Allergies		**Respiratory Problems**	
Rheumatic Fever		**Hallucinations**	
Visual Problems		**Audio Problems**	
Alcohol/Drug Related Seizures		**Arthritis**	
Hepatitis/Liver Disease		**Kidney Disease**	
Pressure Ulcers		**VTE (Venous thromboembolism)**	
Skin or Wound Care Necessary		**Recent Surgery**	
Other: please specify			

Tuberculosis Symptom Inquiry – does this applicant present with any of the following symptoms:

☐ cough ≥ 3 weeks (productive) ☐ fever ☐ night sweats

☐ weight loss ☐ fatigue ☐ hemoptysis

If symptoms suggest active TB disease, chest x-ray and sputum samples for AFB and culture are recommended and possible referral to Tuberculosis Services 403-944-7660.

Influenza Symptom Inquiry – Does this applicant present with any of the following symptoms:

☐ symptoms of fever ☐cough ☐ runny nose ☐ sore throat

☐ body aches ☐ fatigue ☐lack of appetite ☐ diarrhea ☐ vomiting

If symptoms suggest active influenza please direct the client for proper treatment. Clients must be symptom free to attend our Inpatient Treatment Program.

Psychological/psychiatric conditions that might interfere with participation in the program. Are you aware of any conditions (i.e.: extreme anxiety, psychosis, depression, suicide attempts, etc.) that should be taken into account during treatment. Please detail:

_____
_____
_____

Please List all Drug and Food Allergies:

_____
_____

Current Medications	Prescribed by	Date Prescribed	Duration and Reason Prescribed

I certify the above to be true to the best of my knowledge:

_____ _____
Doctor/RN Signature

_____
Date

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CONSENT FOR RELEASE AND COLLECTION OF CONFIDENTIAL INFORMATION

I, _____, give permission to **Sunrise Healing Lodge** to contact:
PRINT NAME

TO/FROM (Please check only those that you have involvement with)	☐ Alberta Health Services ☐ Calgary Drug Treatment Court ☐ Calgary Probation and Community Corrections ☐ Corrections Service Canada ☐ Alberta Works ☐ First Nation Inuit Health Branch (FNIHB), Medical Transport (NIHB) ☐ Assured Income for the Severely Handicapped (AISH) ☐Child and Family Services/Mahmawi-Atoskiwin ☐ Elizabeth Fry Society and John Howard Society ☐ Oxford House ☐ Other: _____

WHAT INFORMATION	For the purposes of arranging funding for treatment, transportation to/from treatment, medical assessment for treatment, housing for pre-treatment, and status of criminal charges, probation or parole to assess appropriateness for treatment.

CONSENT	I understand that provision of treatment services is not entirely dependent upon my decision to release information and that I may cancel this consent at any time. I also understand that some action may have been taken prior to cancellation. Client Signature: _____ Witness: _____ Date signed: _____/____/____ Permission will expire on ____/____/____/

CANCEL	I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation. Client Signature: _____ Witness: _____ Date Signed: _____/_____/_____