OTTAWA BOOTH CENTRE
ADDICTIONS SERVICES APPLICATION PACKAGE

Note to Applicants : *Please complete all aspects of the Addictions Services Application Package.* ***Incomplete applications WILL NOT PROCESSED.*** *Please note that there is no direct entry to the Anchorage Program: all clients will enter residential services through the Stabilization Program.*
***PLEASE BE AWARE THAT NO ELECTRONIC DEVICES ARE PERMITTED IN OUR PROGRAMS AT ANY TIME ***

BASIC INFORMATION		
First Name	**Middle Name**	**Last Name**
Date of Birth *(Month/Day/Year)*	**Source of Income**	**Marital Status**
Street Address *(including city)*	**Phone Number**	**Can we leave messages? YES** or **NO**
Do you identify as a member of a visible minority? YES or **NO** **Do you identify as a person of Aboriginal descent? YES** or **NO**		
What is your primary language? _____	**Status in Canada** **Canadian Citizen Y or N** **Landed Immigrant Y or N** **Other:**_____	**If English is not your primary language, are you able to receive services in English?** **YES** or **NO**
Referral Source: Ottawa Withdrawal Management Centre o Correctional facility/Legal System:_____ o Community organization:_____ o Other (please state): _____		
Emergency Contact Name	**Phone Number**	**Relationship**

PHYSICAL HEALTH			
Family Doctor's Name	**Address of Clinic**	**Date of Last Visit**	**Reason for last visit?**
How many times have you been hospitalized in the past year? _____ *Please describe the reasons for any hospitalizations in the past year*			
Do you have any allergies to foods or medication? **YES** or **NO** *If yes, to what?*			
Do you have any dietary restrictions? **YES** or **NO** *If yes, please describe:*			

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Do you have a history of seizures? **YES** or **NO**
If yes, please describe:

Are you currently <u>taking any</u> medications? **YES** or **NO**
*If you are taking **<u>any</u>** (prescription or over-the-counter) medications, please complete the following table:*

Medication	Dose	Reason	How long have you been taking it?	Are you taking it as prescribed?

Have you previously been prescribed any medications that you are <u>not</u> currently taking? **YES** or **NO**
If yes, please state which medications and why you have stopped taking them:

Do you have any serious medical conditions or Issues with mobility? **YES or NO**

TOLL FREE CONTACT PHONE LINE IS 1-866-446-3030 EXT 306

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Please note that clients can be accepted into Addictions Services while on various types of medications. During the intake process, a medication review will take place by our partners at Respect Rx. All prescriptions will be transferred to Respect Rx for proper packaging and distribution.

In medically **EXCEPTIONAL circumstances, the Addiction Services clinical team may consider after Intake and medication review, that the individual may not be suited for the programs within Addictions Services.*

Please note that any changes to medication(s) **MUST** be discussed with your primary counsellor and reviewed by our Partners at Respect Rx.

Are you in agreement to the above specifications? **YES** or **NO**

Do you currently use any opiate replacement therapies (ie. Methadone, suboxone)?* **YES** or **NO**

We welcome clients who are on opiate replacement therapies. Clients who are new to program may be referred to a doctor if they wish.

*Please be aware that clients are **NOT** permitted to store methadone **anywhere** on site. Clients must have their methadone dispensed daily from a clinic or pharmacy. **Suboxone is accepted on site and is taken in front of a staff member**. Additionally, clients are **not** permitted to start opiate replacement therapies once in Anchorage.

Are you in agreement to the policies surrounding the use of opiate replacement therapies? **YES** or **NO**

*Please note if you answer no to abiding by our opiate replacement therapy policies, we will not be able to accept you into the program

MENTAL HEALTH

Please know that a history of mental health issues does not exclude you from accessing services. In order to best meet the needs of clients in our programs, we request information regarding your mental health history.

Have you ever been diagnosed with a mental health disorder (including but not limited to anxiety, depression, ADHD, schizophrenia, etc. **YES** or **NO**

If yes, please describe:

Have you ever received treatment related to a mental health concern before? **YES** or **NO**

If yes, please state where and when:

Do you believe that you require mental health support? **YES** or **NO**

If yes, please describe:

Is a Mental Health Provider following you? ***YES or NO***

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Have you ever had thoughts of suicide? **YES** or **NO**
Have you ever attempted suicide? **YES** or **NO** *If yes, please state the number of times and date of most recent attempt:*
Do you currently have thoughts of suicide? **YES** or **NO**
EMPLOYMENT
Please note that while in Stabilization & Anchorage, clients are not permitted to work for the purpose of generating income.
Will you be able to commit to not working while in recovery within Addictions Services? **YES** or **NO** *What was your previous area of work? :*
EDUCATION
It is our mission to do our best to serve everyone, regardless of educational abilities or needs. Groups as part of *Addictions Services at The Salvation Army Ottawa Booth Centre are taught using many different styles of instruction and require the ability to read and complete written work. We would like to know about any additional support you may need in order to be able to fully participate in our programs.*
Do you require any assistance in being able to read or complete written work? **YES** or **NO** *If yes, what do you require?*
What is the highest level of education you have completed? _____
Have you ever been diagnosed with a learning or developmental disability? **YES** or **NO** *If yes, please describe:*

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LEGAL

Please note that a history of violent offences does not necessarily exclude you from participating in programming. However, we do want to gather some information in order to best serve you. Staff may also request information pertaining to criminal charges if necessary.

Are you currently involved in the legal system? **YES** or **NO**

Do you have charges pending? **YES** or **NO**

If yes, please state your pending charges:

Are you (or will you be) on bail, probation or parole? **YES** or **NO**

Do you have a Probation/Parole Officer or a Surety?
YES or **NO**
If yes, please provide their name and contact information:

Do you have a lawyer? **YES** or **NO**
If yes, please provide their name and contact information:

Is it mandatory for you to be in a treatment program? **YES** or **NO**

Have you ever been convicted of a violent offence?
YES or **NO**
If yes, please state the nature of the offence(s):

SUBSTANCE USE HISTORY

Presenting Substance Abuse Disorder Issues:

Substance of Choice	How much do you normally use at one time?	How often do you use this substance?	How do you use this substance? (smoke, inject, etc)	How long has this substance use been a problem from you?	Date of Last Use

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Please note that the Addictions Services programs requires a minimum of <u>24 hours of sobriety</u> prior to intake. *In some circumstances, staff may request clients directly from a withdrawal management service. For clients who use marijuana, there is an expectation that urine screens will be negative for THC* ***six (6) weeks*** *following their intake date.* ***Clients may be discharged from program if urine screens after 6 weeks are not negative for THC.***

Do you identify as having a co-occurring addiction (gambling, sex, shopping, etc.)? **YES** or **NO**

If yes, please describe:

VACCINATION REQUIREMENTS

DOUBLE VACCINATED ONLY ACCEPTED

___ **PLEASE CHECK IF YOU ARE DOUBLE VACCINATED**

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TREATMENT HISTORY AND GOALS

Have you ever been to a treatment program for substance use in the past? YES or **NO**

If yes, please complete the following table:

Name of Agency	Dates	Length of Program	Did you complete the program?	If you did not complete the program, what was the reason?

LONG TERM TREATMENT OPTIONS

The Stabilization Program is available to support you for up to 90 days while you work towards your goals in recovery. While in Stabilization, many clients pursue long-term treatment.

Please describe where you plan on going after Stabilization (i.e. Anchorage, other treatment programs):

COMMUNAL LIVING

Please be aware that the Stabilization program is located in an emergency shelter setting. The program is located on the 4th floor of the building and the bedrooms are shared by two to four residents each.

Are you comfortable living in a communal living setting? YES or **NO**

Have you ever had any problems with communal living? YES or **NO**

If yes, please describe:

In signing below, I acknowledge that all of the information in this application is true to the best of my knowledge. I also agree to all of the expectations defined in this application.

Applicant Signature _____ Date _____

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To be filled out by the interviewer

Client Name: a._____ b.___ c._____
(First name) (M.I.) (Last name)

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS CAMH ver.3.1.0

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or attempting suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people.	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d. drove a vehicle while under the influence of alcohol or drugs?	4	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a. missing meals or throwing up much of what you did eat to control your weight?	4	3	2	1	0
b. eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	3	2	1	0
c. being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	4	3	2	1	0
d. thinking or feeling that people are watching you, following you, or out to get you?	4	3	2	1	0
e. videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	0
f. gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioural, or personal problems that you want treatment for or help with? (If yes, please describe below)..... Yes 1 No 0

v1. _____

_____

6c. What is your gender?

(Select one)

- Intersex..... ☐
- Man..... ☐
- Non-binary..... ☐
- Trans Man..... ☐
- Trans Woman..... ☐
- Two-Spirit..... ☐
- Woman..... ☐
- I don't identify with any of these options..... ☐
- Prefer not to answer..... ☐

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only

8. Site ID: _____ Site name v. _____

9. Staff ID: _____ Staff initials v. _____

10. Client ID: _____ Comment v. _____

11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered

13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____

15. Referral comments: v1. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				
Supplemental questions	AQ5a-f				