Edmonton Centre of Hope

Cornerstone Program

Preliminary Intake Assessment Form

11838 82 Street Edmonton AB Message line: 780-474-7499

Send completed form to:
Fax: 780-474-4600
Email: echo.info@salvationarmy.ca

This form is to be completed by the participant or a referral worker on the participant's behalf.

PLEASE NOTE: **ALL SECTIONS MUST BE COMPLETED**. INCOMPLETE APPLICATIONS WILL BE Invalid.

This is a preliminary intake assessment; **not an intake package**. Upon receipt of this assessment, the intake team will assess this application and a team member will contact you or your referral worker. This is the first step in the intake process.

1. Complete this Preliminary intake package. *This is an intensive live- in program*. Call with any questions.
2. Send completed package to Cornerstone via Fax: 780-474-4600. or echo.info@salvationarmy.ca Type Cornerstone" in the subject line. Or by mail.
3. Receive a step 2 acceptance letter via mail or email or a telephone call and perform a telephone or virtual interview. *You may be placed on a wait list.
   - **If you do not have a means for us to contact you; please contact us 7 days after submitting your application**
4. Receive an intake date. Please arrive by 8:30 am on the date given.

Referred by:
- ☐ Self
- ☐ Remand/Justice ()
- ☐ Alberta Health worker
- ☐ Social worker
- ☐ Immigration Service
- ☐ Other: _____

Centre Use Only:

Received Date: (D/M/Y)____/___/___

Confirmed with participant Date: (D/M/Y)_/___/___

Accepted/Declined-reason: _____

Intake Date: (D/M/Y)____/___/___

Edmonton Centre of Hope

Admission Criteria:

The criteria for acceptance in the Cornerstone Program are as follows:

- Female (identify as) - minimum age of 18 years.
- Substance abuse free for a minimum of 90 days as verified by physician, hospital, or Treatment program. Meet at least one of the following criteria:
  - has successfully completed an addictions treatment program;
  - has lived free from alcohol and the use of illicit drugs for a minimum of three (3) months;
  - has been referred to The Salvation Army by a recognized referral agency;
  - has requested that The Salvation Army provide the services to the Participant which are described in the Service Agreement (self-referral).
- Medically and psychologically stable and requires no medical appliances such as IV's, oxygen, wheelchair, walker. Participants must be fully ambulatory including ability to navigate stairs unassisted. Must be able to live independently. Tend to all ADLs.

  The Salvation Army does not discriminate based on any disability. These restrictions are predicated upon the structure of the facility which has no elevators, and upon the capacity of staff that are not qualified to care for persons with complex medical issues.
- If there is a documented mental health disorder the participant must be stable.

- Be able and willing to properly store all medications and take all medication(s) as prescribed.
- Agree to store all belongings in the assigned suite. Understand that excessive personal belongings, garbage, open food, and weapons are not permitted and will be removed.
- Must be financially capable of paying for the damage deposit, and monthly accommodation/program fees.
  - Participants admitted to the Cornerstone Program will provide urine samples.
  - Can care for own personal hygiene, able to participate in housekeeping duties.
  - Has an intent to complete 1 year the program.
  - Will participate in the smoking cessation program.
  - Willing to abide by the program philosophy, polices, schedules, and rules of the program, and willing to participate in all program components which include counseling, group work, class work, homework, spiritual care, physical activity, service opportunities (chores), care of participant area, and all relevant activities scheduled by Program staff.

Edmonton Centre of Hope

PART 1 – PARTICIPANT INFORMATION

Complete the following in the spaces provided. If any information is not applicable indicate as NA, unknown as UNK and unavailable as UNA. Please mark all questions.

A. General Information

Surname:		First Name:		Nickname (or other name known by):	
Date of Birth: D M Y		Age:	Gender: ☐ Female ☐ male	Provincial Health Card Number:	
Address:					
Telephone:	Home:		Cell:	If you do not have a phone, how can we contact you:	
Language(s):	Spoken:		Understood:	Preferred:	
Status?	☐ Yes ☐ No	Band Name:		Treaty #:10 digit.	
Emergency Contact:		Telephone:		Relationship:	
Person who my belongings can be released to :	Name:	Phone:	☐ Same as above.		
Education Status:		Last grade/educational program completed:			
Literacy Level **					

RELATIONSHIPS

Marital Status:	☐ Single	☐ Married	☐ Common-Law	☐ Widowed	☐ Separated	☐ Divorced

If prescriptions or ambulance are required; how will it be paid for?

Alberta works AISH Blue Cross Health Canada (INAC) Other:

Child/Dependent's Name	Gender:	Age	Relationship
	☐ Female ☐ male		
	☐ Female ☐ male		
Are you adopted/Spent time in foster care	☐ Yes ☐ No		
Do you have any spiritual/ religious beliefs?	☐ Yes ☐ No		

Edmonton Centre of Hope

Family members; substance or mental health struggles.	Comments: ☐ Yes ☐ No
Supportive people in my life:	

EARLY EXIT PLAN	
The following will be put in place if I leave Cornerstone early. I understand that as I continue, the program will assist me to develop a more complete transition plan to ensure my continued support and recovery when returning to free market housing is understood that if I leave the program on short notice or if I do not arrive for my scheduled intake, my referral liaison and my emergency contact will be notified immediately.	
Participant Name:	
Key Community Contact for Transition Plan (Name/Relationship):	
Phone: Email:	
Emergency Contact and/or Next of Kin (Name/Relationship)	
Phone: Email:	
Community/Health Authority Contact (Name/Agency):	
Phone: Email:	

LEGAL INFORMATION

	Probation Order attached? ☐ Yes ☐ No

Is the participant under any of the following legal conditions?

☐ Bail ☐ Parole ☐ Temporary Absence Order ☐ House arrest/needs supervision for outings

☐ Other (provide details, dates, etc.) ☐ Is on a registry

**** If currently in Remand- Please provide a way to contact participant.**

Contact for Legal issues:_____ Role_____ Phone:_____ Email:_____

Edmonton Centre of Hope

TREATMENT HISTORY

Has participant participated in a substance misuse and/or mental health program? ☐ Yes ☐ No				
If yes, describe program(s):				
Is participant currently prescribed:				
Methadone ☐ Yes ☐ No	Suboxone ☐ Yes ☐ No * Please review list of medications not permitted on last page			
Has participant participated in a residential treatment program before? ☐ Yes ☐ No	Longest term of sobriety:			
How did you maintain your sobriety?				
If yes, please provide information on previous treatment experiences:				
Year	**Treatment Centre**	**Type of Addiction**	**Completed**	**Comments**
			☐ Yes ☐ No	
			☐ Yes ☐ No	
Describe participant's reason(s) for currently requesting to enter the Cornerstone program:				
The most important "goal for me right now" is?				

B. Substance(s) Used

SUBSTANCE Circle specific substance(s) or print name	**Pattern & Frequency of Use** In last 6 months: Occasional, Daily, Weekly, Monthly, Binge, Other	**Method of Use** N = nasal/snort O = oral/swallow IV = inject IS = inhale/smoke	**Average Amount Used** In a 24-hour period)	**Length of Time Used** In days, months, years	**Date Last Used** Include time if known
Alcohol: E.g. beer, wine, coolers, liquor, homebrew, Lysol®, hairspray, mouthwash, aftershave, etc.					

Edmonton Centre of Hope

Marijuana: E.g., pot, hash, hash oil, etc.					
Cocaine: E.g. Crack, powder					
Inhalants/Solvents: E.g. Lacquer, glue, paint thinner, gasoline, aerosol sprays, amyl nitrate, etc.					
Club Drugs: E.g. Ecstasy (MDMA), GHB, Rohypnol, Ketamine, etc.					
Hallucinogens: E.g. Psilocybin mushrooms, LSD, Peyote, PCP (Angel Dust), Mescaline, DMT					
Amphetamines: E.g. Crystal meth, speed					
Illicit Street Opiates: E.g. Heroin, Opium					
Fentanyl Illicit Fentanyl or prescription, e.g. Duragesic®, Sublimaze®, Actiq®					
Prescription Opioids: E.g. Codeine (T-2s, T-3s,) Oxycodone (Percodan®, Percocet®), Hydrocodone (Lortab®, Lorcet®) Dilaudid®, Darvon®, Morphine, Demerol®, etc.					
Prescription Sedatives, Tranquilizers, Barbiturates, Benzodiazepines E.g. Valium®, Ativan®, Serax®, Rivotril®, Halcion®, Librium®, Xanax®, Mogodon®, Nembutal®, Luminal®, Ambien®, etc.					
Prescription Stimulants: E.g. Ritalin®, Dexedrine®, Adderall®, Concerta®, etc.					
Gabapentin (Neuronton®)					
Over the Counter Drugs: E.g. Codeine (T-1s), Gravol®, Cough Syrup with Dextramethorphan (DXM) etc.					
Anabolic Steroids					

Substance(s) of choice: 1. _____ 2. _____ 3. _____

Edmonton Centre of Hope

C. Withdrawal Affects

Has participant experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptom			Comments
Blackouts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Hallucinations	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Nausea/vomiting	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Seizures	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Shakes	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Delirium Tremens (DTs)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Violence	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Days substance free:	Did you attend a detox? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Not applicable ☐ Unknown

D. Process/Behavioral/Emotional Struggles

Has participant experienced struggles with any of the following?

Process/Behavioral/Emotional Struggles			Comments
Gambling (slots, cards, Keno, bingo etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Sex (promiscuity, etc.)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Internet, texting, social media, phone.	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	
Grief/loss/	☐ Yes ☐ No		Comments:

Edmonton Centre of Hope

E. Mental Health

Provide the following information about the participant's mental health status:

Mental Illness			Description
Been diagnosed with mental illness(es)	☐ Yes ☐ No	☐ Unknown	If yes, is medical documentation attached? ☐ Yes ☐ No ☐ Not applicable
Currently being treated for mental illness(es)	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, what treatment is being provided and by whom?
Currently on psychiatric medication	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, describe medication.
Taking medication consistently	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	Please describe.
Previous suicide attempts?	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, when? Comments.
Hospitalized for suicide attempts	☐ Yes ☐ No	☐ Not applicable ☐ Unknown	If yes, when? Comments.
Currently suicidal	☐ Yes ☐ No	☐ Unknown	Comments:

F. Other Issues/Needs

Provide information about other participant issues and needs:

Describe participant's cultural and/or spiritual beliefs and practices that we need to be aware of.

Describe other significant issues we need to be aware of. (Reading, writing, hearing, vision, ability to sit or stand for periods, has been recently hospitalized, chronic or brain injury, dysregulation of emotions)

Currently:

☐ self-mutilation	☐ aggressive behaviors	☐ violent temper	☐ depressed mood
☐ poor grooming/hygiene		☐ poor concentration	☐ sleep disturbance
☐ hyperactivity	☐ paranoid ideation	☐ dissociative states	☐ mood swings
☐ delusions	☐ hallucinations	☐ generalized anxiety	☐ panic attacks
☐ hopelessness	☐ phobias	☐ social isolation	☐ worthlessness
☐ other (specify)			

Comments:

Edmonton Centre of Hope

G. Application Checklist

Reviewed my medications with Doctor for suitability for program	☐ Yes ☐ No
Provided copies of any legal orders or probation requirements	☐ Yes ☐ No
Confirmation of funding and damage deposit.	☐ Yes ☐ No
Completed all questions with an answer or N/A	☐ Yes ☐ No
Completed Preliminary Assessment package sent to via instructions on front/Keep copy for yourself	☐ Yes ☐ No
Confirmation interview and intake date received	☐ Yes ☐ No
Verifiable clean time of 90 days upon intake date	☐ Yes ☐ No
Read, meet understand and agree to the admission criteria.	☐ Yes ☐ No
Participant understands there is an recommendation of completion aftercare counselling sessions	☐ Yes ☐ No

Edmonton
Centre of Hope

Letter of Introduction

Please write a one-page letter: Why you have chosen to enter the Cornerstone Program:

Edmonton Centre of Hope

PART 2 – REFERRAL Worker Information or check box if self-referral or no worker and skip this section

☐

Referral Worker Name:		Title:	
Agency:		Telephone:	
Fax:		Email:	
Address:			

Will you continue to see the participant? ☐ Yes ☐ No If no, please explain:

What other supports would be available to your participant?

Name/Resource	Description of Support

Briefly summarize all assessment processes completed with the participant (e.g. CAGE MAST, DAST, Treatment Readiness, etc.) which support the application, and evaluate how substance dependence have affected your participant in all domains (e.g. domestic, medical, social, psychological, spiritual, and emotional). Include scoring and interpretations. Attach a separate sheet if necessary or the assessment summary from your participant file.

Please list any questions or concerns the participant has indicated during the intake process.

What other areas might need to be addressed? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.)

Edmonton Centre of Hope

Referral Agent assessment of participant's strengths and potential challenges.

Referral Checklist

Please initial which applicable items have been completed. Check off any items attached to this application:

Item	Attached	Initials
Psychiatric evaluations	☐	
Probation order	☐	
Current Medical Assessment form	☐	
Assessment Summary	☐	
Substance Abuse Profile	☐	

Please initial each item that has been completed:

Item	Initials

Referral Signature

Date (D/M/Y)

Edmonton
Centre of Hope

Participant Authorization

I authorize the documentation of my information for this application process. I understand and agree to accept the program as described by the Salvation Army. I understand failure to adhere or dishonest answers may result in my not being accepted on my intake day. An intake urine screen and random screenings are part of the program; positive result for tested substances can result in being released from the program or being denied intake. I understand this is an intensive residential program, with guidelines and modules; required for my successful completion. I understand this is a 1year session. I understand counselling and therapeutic interventions are part of this program. I understand that smoking cessation is part of the program I understand my full participation and attendance to all components of the program is necessary.

_____ _____

Participant Signature Date (D/M/Y)

_____ _____

Referral Signature Date (D/M/Y)

WAIVER TO RELEASE INFORMATION

I, _____
Print Name
Authorize The Salvation Army to obtain or release information contained in this Intake Application. The purpose of sharing information with other health professionals, agencies, or institutions involved in the Assessment/Placement/Treatment process will be for the continuity of my care**.**

Applicant Signature _____ (Date) _____
yyyy.mm.dd

Witness/Intake staff Signature:_____ (Date) _____
yyyy.mm.dd

Consent to Psychotherapeutic counselling.

I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a participant. I consent to participate in counseling and assessment. I understand confidential counselling records will be kept; I can request to see these records.
Psychotherapy involves a degree of risk. You may experience uncomfortable emotions as you talk about the issues that are concerning you. Sometimes therapy involves talking about unpleasant aspects of your history. Psychotherapy is focused on facilitating change according to the goals you set.
Counselling is part of the Transformations program.
Exceptions to Confidentiality:

- The staff in the Salvation Army Programs work as a team and have access to view "all" participant files and case notes, including test results and your Counsellor's case notes of your counseling sessions. Your counsellor may consult the team without your authorization.

Edmonton Centre of Hope

- If there is evidence of clear and imminent danger of harm to self and/or others, a counsellor is legally required to report this information to persons responsible for ensuring safety.

- Counseling staff that learn of, or strongly suspect, child or elder abuse (physical or sexual) must report this information to the authorities.

- A court order may require a release of the information contained in your records and/or require a counsellor to testify in a court hearing.

Applicant Signature _____ (Date) _____
yyyy.mm.dd

Witness/Intake staff Signature_____ (Date) _____
yyyy.mm.dd

Edmonton Centre of Hope

The following are medications not permitted in the Cornerstone Program.

Opioid Pain medications:

Codeine & products containing Codeine (eg. Tylenol 3)
Morphine (eg. Kadian)
Fentanyl
Hydromorphone (Dilaudid)
Pentazocaine (Talwin)
And all others.

Oxycodone(Percocet, OxyNeo)
Meperidine (Demerol)
Tapentadol (Nucynta)
Tramadol(Zytram, Ralivia, Tridural)
Propoxyphene(Darvon)

Benzodiazepines:

Alprazolam (Xanax)
Lorazepam (Ativan)
Temazepam (Restoril)
Chlordiazepoxide (Librium)
Clorazepate (Tranxene)
Flurazepam (Dalmane)
And all others

Bromazepam(Lectopam)
Oxazepam (Serax)
Triazolam (Halcion)
Clonazepam (Rivotril)
Diazepam (Valium)
Nitrazepam (Mogadon)

Psychostimulants:

Dextroamphetamine (Dexedrine)
Lisdexamfetamine (Vyvanse)
Modafinil (Alertec)
And all others

Amphetamine Mixed Salts (Adderall XR)
Methylphenidate (Ritalin, Biphentin, Concerta)

Miscellaneous:

Varenicline (Champix)
Dronabinol (Marinol)
Zopliclone (Imovane)

Nabilone (Cesamet)
Medical Marijuana

What if I am on a restricted medication? We have 3 suggestions for restricted medications prior to admission:

1. Make a plan with your physician to taper off of the medication.
2. Request an alternative medication to the one on the restricted list.
3. In the event that a physician feels there is no alternate; a medical note may be written by them stating their case.

   This note must contain:

   a. What the medication is being used to treat
   b. What the dose is
   c. What is the duration of use
   d. Statement that there is not alternate
   e. What happens if the participant is not on this medication

f. Statement that the physician believes this medication would contribute to the participant successfully completing addictions treatment.