Keystone Program

Preliminary Intake Assessment Form

11830 85 Street Edmonton AB Message line: 780-490-6501

Send completed form to:
Fax: 780-477-2532
Email:
Ecoh.info@salvationarmy.ca

This form is to be completed by the client or a referral worker on the client'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 Keystone via: Email – ecoh.info@salvationarmy.ca Fax: 780-477-2532. Type Keystone 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 client Date: (D/M/Y)_____/___/___

Accepted/Declined-reason: _____

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

Admission Criteria:

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

- Male/Identifies as male - minimum age of 18 years.
- Has completed a residential substance dependence treatment program
- Medically and psychologically stable and requires no medical appliances such as IV's, oxygen, wheelchair, walker. Clients must be fully ambulatory including ability to navigate stairs unassisted. Must be able to live independently Can care for own personal hygiene.
- If there is a documented mental health disorder the client 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.
- Provide Urine samples as requested for drug screening tests
- Willing to engage in building and review of a Transitional Plan.
- Willing to complete the actions agreed upon in the Transitional Plan
- Consents to searches
- Willing and , able to participate in housekeeping duties.
- Has an intent to complete the program.
- Will participate in a 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 may include counseling, group work, class work, homework, spiritual/emotional care, physical activity, assessments, service opportunities (chores), care of client area, and all relevant activities scheduled by Program staff.**

PART 1 – CLIENT 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: ☐ Male ☐ Female	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:	
Do you have any communicable disease?		Are you taking any Opiate therapy?	

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
	☐ Male ☐ Female		
	☐ Male ☐ Female		
Are you adopted/Spent time in foster care	☐ Yes ☐ No		
Do you have any spiritual/ religious beliefs?	☐ Yes ☐ No		

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 program 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 it 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.	
Client 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 client 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

.

Contact for Legal issues:_____Role_____Phone:_____Email:_____

TREATMENT HISTORY

Is client currently prescribed any opiate replacement or agonist therapy?

If so what:

Methadone ☐ Yes ☐ No	Suboxone ☐ Yes ☐ No
Has client 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 client's reason(s) for currently requesting to enter the program:

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.					
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. _____

C. Withdrawal Affects

Has client 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	

D. Process/Behavioral/Emotional Struggles

Has client 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:

E. Mental/Medical Health

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

Mental Illness			Description
Been diagnosed with mental/Medical illness(es)	☐ Yes ☐ No	☐ Unknown	If yes, is medical documentation attached? ☐ Yes ☐ No ☐ Not applicable
Currently being treated for mental/ Medical 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:	
Medical issues			
Medications currently prescribed			

F. Other Issues/Needs

Provide information about other client issues and needs:

Describe client'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:

Letter of Introduction

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

The most important "goal for me right now" is?

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 client ? ☐ Yes ☐ No If no, please explain:

What other supports would be available to your client?

Name/Resource	Description of Support

Briefly summarize all assessment processes completed with the client (e.g. CAGE MAST, DAST, Treatment Readiness, etc.) which support the application, and evaluate how substance dependence have affected your client 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 client file.

Please list any questions or concerns the client 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.)

Referral Agent assessment of client'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) _____

Client 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/searches 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 up to an 12 month commitment.. 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. I understand I will be accountable to the Transitional Plan .

_____ _____

Client 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. (if available)

I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client. 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 Transformations Program work as a team and have access to view "all" client 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.
- 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

The Salvation Army
Edmonton Centre of Hope
Edmonton, Alberta

AUTHORIZATION TO RELEASE AND/OR OBTAIN CLIENT INFORMATION

I **agree** that my personal information may be shared with Service Providers and/or any persons or agencies acting on behalf of these organisations, who can contribute to my care. The information may be collected from sources such as:

- Federal, provincial, and municipal government departments
- Healthcare, medical and pharmaceutical agencies and professionals
- The Police
- Medical, Psychological/Functional reports

I **understand** that this information will be used for the purpose of service and/or care provision.

I **understand** that I may revoke this authorization at any time by giving written notice to the Salvation Army office. I also understand that the withdrawal of my authorization to share information may result in a reduction of services being available to me.

I **understand** that I have the right to restrict what information may be shared and with whom, and this may affect the provision of care to me.

I **understand** that by signing this form and joining this program I am **agreeing that recording is used in all public areas(in/outdoor)** of the property, may be stored, may be released to any of the above.

I **understand** that my information will be held securely on paper and on computer in compliance with the Freedom of Information and Protection of Privacy Act.

I have made the following restrictions/limitations (if applicable please list restrictions)

_____

I, _____ authorize the Director or delegate of the
Client's name / Guardian representing the client

Salvation Army office to release and/or obtain information regarding so that my support services can be properly coordinated and implemented. Or pertaining to a criminal matter.

_____
(Client's name) First Middle Last

_____ _____
Client/Guardian Signature ***Date***

_____ _____ _____
Witness/ Salvation Army Signature ***Date*** ***Position***

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
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
Read, meet understand and agree to the admission criteria.	☐ Yes ☐ No
Client understands there is an recommendation of completion aftercare counselling sessions upon completion of residential treatment.	☐ Yes ☐ No

The following are medications not permitted in the Keystone 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 client is not on this medication

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