Interior Health

YOUTH SUBSTANCE USE TREATMENT APPLICATION

Patient Name *(last)* _____

(first) _____

DOB *(dd/mm/yyyy)* _____

PHN _____ MRN _____

Account/Visit # _____

IH USE ONLY

Treatment Centre Information

The following treatment centres are available to youth who reside in the Interior Health region. Please indicate your placement preference.

- ☐ No preference, first available space
- ☐ The Bridge - Kelowna: *Youth Recovery House*
- ☐ Active Care - Kamloops: *A New Tomorrow Treatment Solutions*

Why do you prefer this location? _____

PART A – Youth Information Questionnaire

To be completed by Participant with assistance, as needed.

Legal First Name _____ Legal Last Name _____

Preferred Name _____ Date of Birth (dd/mm/yyyy) _____

PHN _____ Sex (at birth) ☐ M ☐ F Gender Identity _____ Pronouns _____

Address _____

Phone _____ Email _____

How do you want to be contacted? ☐ Phone (☐ OK, to leave message) ☐ Text ☐ Email

Who do you live with? ☐ Parent/Legal Guardian ☐ Friend ☐ Homeless/Shelter ☐ Relative ☐ Foster Care ☐ Other (specify) _____

Legal Guardian Information

Name(s) _____

Address _____

Phone _____ Email _____

Education

Are you currently attending school? ☐ Yes ☐ No Date last attended _____

School Name & District _____

School staff contact _____ Phone _____

Cultural Information

Do you self-identify as Aboriginal? ☐ Yes ☐ No

Languages spoken _____

We invite the participant to let us know if there are any spiritual, religious practices or ceremonies that will support their wellness while in treatment. _____

Legal History

1. Do you have any outstanding charges? ☐ Yes ☐ No
   If yes, please describe. _____
2. Do you have any upcoming court dates? ☐ Yes ☐ No
   If yes, when and do you need transportation support? _____
3. Are you currently on bail/probation? ☐ Yes ☐ No
   If yes, please send copy of bail/probation order with application.

Permanent part of the health record

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Housing / Accommodation

Please tell us about your current and post treatment housing.

1. Do you currently have safe housing? If yes, please describe housing arranged for after treatment (include address if available). If no, please describe safety concerns. ☐ Yes ☐ No

2. Are you currently homeless? If yes, please describe situation. ☐ Yes ☐ No

3. What is your housing plan after treatment?

4. How will you travel home? Is assistance needed with travel to / from treatment?

Mental and Physical Wellbeing

1. Do you have any disordered eating habits (i.e. restricting, bingeing)? If yes, please describe. ☐ Yes ☐ No

2. Do you have any self-injury behaviors (i.e. cutting, burning)? If yes, please describe and include most recent date. ☐ Yes ☐ No

3. Do you have any suicidal thoughts and / or have attempted suicide? If yes, please describe. ☐ Yes ☐ No

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4. Do you experience aggression or anger toward others or history of harming others? If yes, please describe. ☐ Yes ☐ No

5. Would you like family counselling during your stay? ☐ Yes ☐ No

6. Do you have any suspected mental health conditions? (e.g. depression, Post Traumatic Stress Disorder (PTSD), anxiety) If yes, please describe. ☐ Yes ☐ No

7. Do you have any suspected or diagnosed physical concerns? (e.g. Fetal Alcohol Syndrome Disorder (FASD), Acquired Brain Injury (ABI), seizures, kidney/liver issues) If yes, please describe. ☐ Yes ☐ No

8. Do you have any dietary needs? If yes, please describe. ☐ Yes ☐ No

9. Have you experienced concerns with any of the following during the **PAST YEAR**? If yes, select all that apply. ☐ Yes ☐ No
   ☐ Gaming ☐ Pornography ☐ Gambling ☐ Sexuality ☐ Identity
   ☐ Self-esteem ☐ Social media ☐ Sleep ☐ Relationships

10. Have you been hospitalized for any reason in the last year? If yes, please describe. ☐ Yes ☐ No

11. Do you have any health concerns that may impact your ability to participate fully in programming? Let us know if you require specific accommodation. ☐ Yes ☐ No

Date (dd/mm/yyyy)	Time (24 hour)	Completed by Name/Signature	Designation/College ID#
/ /			

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PART B – Substance Use and Treatment History Questionnaire

To be completed by Participant with assistance, as needed.

1. Have you ever been in a treatment program (including day programs) to get help with substance use? ☐ Yes ☐ No
2. Please complete this chart to the best of your ability.

	Substance	Method of use (smoke, IV, etc.)	Amount/quantity used when using	# of days used in the last 30 days	Date of last use (dd/mm/yyyy)	Treatment goal (stop use, reduce harm, etc.)
Opioids (e.g. heroin)						
Alcohol						
Nicotine						
Stimulants (e.g. cocaine)						
Benzos (e.g. valium)						
Other						

3. What else do you hope to accomplish during your time with us (school, work, family, etc.)?

Circle of Care

Please indicate additional people within your circle of care that you would like to be included in planning and supporting your care.

	Name	Phone	Email
Social Worker			
Counsellor			
Mental Health Worker			
Family Support Worker			
Elder			
Physician			
Bail/Probation Officer			
Other (psychiatrist, psychologist, mentor, etc.)			

Date (dd/mm/yyyy)	Time (24 hour)	Completed by Name/Signature	Designation/College ID#
/ /			

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