

Miklat Applicant Admission Form

(Complete and fax to 604-483-9397)

Full Legal Name: <input style="width: 95%;" type="text"/>		
Date of Birth: <input style="width: 150px;" type="text"/>		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Address: <input style="width: 95%;" type="text"/>		
City: <input style="width: 150px;" type="text"/>	Prov: <input style="width: 100px;" type="text"/>	Postal Code: <input style="width: 100px;" type="text"/>
Cell No: <input style="width: 150px;" type="text"/>	Email: <input style="width: 400px;" type="text"/>	
Care Card No. (MSP): <input style="width: 550px;" type="text"/>		
Aboriginal Ancestry Yes <input type="checkbox"/> No <input type="checkbox"/>	SIN#: (required) <input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>
Emergency Contact Name: <input style="width: 250px;" type="text"/>	Emergency Contact #: <input style="width: 150px;" type="text"/>	Relationship to Contact: <input style="width: 150px;" type="text"/>

Referral Source Information

Name/Title Of Referral Worker: <input style="width: 250px;" type="text"/>	Agency/Band: <input style="width: 250px;" type="text"/>	Phone Number # <input style="width: 250px;" type="text"/>
Mailing Address: <input style="width: 580px;" type="text"/>		
City: <input style="width: 150px;" type="text"/>	Prov: <input style="width: 100px;" type="text"/>	Postal Code: <input style="width: 100px;" type="text"/>
Cell No: <input style="width: 150px;" type="text"/>	Email: <input style="width: 400px;" type="text"/>	
Currently receiving disability, social assistance?	Disability <input type="checkbox"/>	<input style="width: 150px;" type="text"/>
	Ministry <input type="checkbox"/>	<input style="width: 150px;" type="text"/>

Please note: Clients collecting social assistance or disability assistance through the Ministry of Social Development will have reduced assistance payments while in treatment.. Rent is covered while in treatment if Ministry is currently paying rent.

Client Demographics

<input type="checkbox"/> Single	<input type="checkbox"/> Common Law	<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
<input type="checkbox"/> Extended Family	<input type="checkbox"/> Living Alone	<input type="checkbox"/> Single Parent	<input type="checkbox"/> Living With Friends	<input type="checkbox"/> Living With Family	<input type="checkbox"/> Living with Spouse & Children
Number Of Dependent Children <i>Choose</i>					

Employment Status

<input type="checkbox"/> FT	<input type="checkbox"/> PT	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired	<input type="checkbox"/> Student
<input type="checkbox"/> Home Maker	<input type="checkbox"/> Disability	Source Of Income:		Other Income:	
Occupation:					

Education Status

Highest Level of Education Completed:	Grade Completed <i>Choose an item.</i>	<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Trade School
	<input type="checkbox"/> College Diploma	<input type="checkbox"/> University Degree	<input type="checkbox"/> Graduate Degree
Have you ever attended Residential School?	Yes <input type="checkbox"/> No <input type="checkbox"/>	When /Where?	
Do you have difficulty with reading?		Do you have difficulty with writing?	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Will the client require assistance with reading or writing?		Does the client have any learning problems or disabilities?	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the client agree to complete NA Steps 1 to 5?		Does the client agree to complete a guided daily journal?	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

Prior Treatment and/or Counselling

Institution	Location	Date	Completed?	
			Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Yes <input type="checkbox"/>	No <input type="checkbox"/>

Conflicting Issues

Does the client express the desire (willingness) to change?		Does the client believe addiction is a problem to his/her wellbeing?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The client understands implicitly and is able and willing to adhere to Miklat program guidelines?		If yes, has the client read and understood Miklat program guidelines?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Is the client free from all factors that would interfere with the Miklat program? <i>(Family, Work, School, Medical, Legal, Childcare, Court appearance, etc.)</i>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does client have discharge plans? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the client have basic needs that aren't currently addressed? <i>(housing, food etc.)</i>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the client have specific needs to be addressed in treatment?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please provide further details below. <i>(ie, legal issues, medical, homeless)</i>	
Does the client have Learning Disabilities?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please explain below.	

Substance Use/Misuse History

Substance	How often used - <i>Daily/Weekly/Monthly</i>	Amount- quantity	Method of use <i>Inject, Smoke, Ingest, Snort</i>	Date last used -
Alcohol (beer, wine, hard liquor)				
Cannabis				
Cocaine				
Benzodiazepines- sleeping pills - tranquilizers				
Heroin/Fentanyl				
Opiates - Morphine/Codeine				
Amphetamine - Crystal Meth, Ecstasy/Speed				
Hallucinogen(acid, Mushroom, PCP, Ketamine				
Inhalants				
Tobacco				
Other				



Ph. 604-483-6462
 Fax. 604-483-9397
 support@miklatsociety.org
 www.miklatsociety.org

Early Exit Plan/Transition Plan *(Must be completed by client)*

The following Early Exit Plan is mandatory, and will be put in place immediately if I choose to leave early from the **Powell River Miklat Recovery House Society**:

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. My plan includes a safe place to go and how I plan to get there.

I agree that I am responsible for all of my transportation costs and that I am responsible for knowing the fees associated with bus, airplane, cab and/or ferry for safe travel. I will have these funds available to me upon intake and will have the money held for safekeeping or taken care of by my referral worker.

My name: <input type="text"/>	Date of birth: <input type="text"/>
Destination upon early exit: <input type="text"/>	My Home Address: <input type="text"/>
Transportation Plan and cost: <input type="text"/>	
My medical reminders: <input type="text"/>	Special considerations: <input type="text"/>

My Community Contact(s) for Early Exit Support:

Who I can contact: <input type="text"/>	Who staff can contact: <input type="text"/>
Telephone # <input type="text"/>	Telephone # <input type="text"/>
Email address: <input type="text"/>	Email address: <input type="text"/>
My Signature and or Referral Worker: <input type="text"/>	Date: <input type="text"/>



Ph. 604-483-6462
 Fax. 604-483-9397
 support@miklatsociety.org
 www.miklatsociety.org

Consent for Release of Information

Client Full Name:

DOB:

Record No: (Office use)

By signing the electronic copy below, I verify that the information I have provided to the Referral Agent noted below, is strictly for the purposes of this referral and my application to attend programming at the Miklat Recovery Society's program.

This information in the Referral Package is accurate to the best of my knowledge. My electronic signature authorizes the release and exchange of information between Miklat Recovery House, and all service providers noted below. This authorization is valid once completed, and will be used pre-arrival, and during my treatment residency with Miklat Recovery House.

Service Provider	Name	Agency	Contact No.
Physician (GP)	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
MH Counsellor	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
Psychiatrist	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
Probation/Parole Officer	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
Income Assistance	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
Lawyer	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
Referral Worker/Agent	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
Other	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
Clients Signature:			Current Date:
<input style="width: 95%; height: 25px;" type="text"/>			<input style="width: 95%; height: 25px;" type="text"/>
Referral Agent Signature:			Current Date:
<input style="width: 95%; height: 25px;" type="text"/>			<input style="width: 95%; height: 25px;" type="text"/>

Program Guidelines for All Clients (*subject to change)

1. In the event of a medical emergency, please contact staff immediately.
2. In the event of a fire alarm, exit the building and muster in the area of the front driveway away from the house.
3. Clients must respect and follow the direction of the staff, if a client become defiant or disrespectful of the staff or the rules, they may be put on a behavioral contract or be discharged from the house.
4. Clients will be required to submit to a urinalysis or breathalyser upon intake and at request while at Miklat, if a client refuses, they will be discharged from the program. Possession or consumption of alcohol or drugs, or possession of paraphernalia is prohibited.
5. We have a zero-tolerance policy for violence of any kind. Violent behaviour including actions, threats of any kind, or possession of weapons will result in discharge from the program. This includes communications and interactions with people outside of the recovery house.
6. We have a zero-tolerance for stealing. This includes stealing from clients, stores, the house, or staff and anyone caught stealing will be discharged.
7. Clients should not lend, borrow, trade, barter, or possess property or money that does not and/or did not belong to them when arriving at Miklat.
8. Entering an establishment that is licensed primarily for the sale or consumption of alcohol or marijuana is prohibited.
9. All medications and prescriptions must be handed in. If clients receive a medical prescription, hand it into the office. All prescription medications must be blister packed before arriving at Miklat or they will not be dispensed.
10. Clients are on lockdown for the first week of treatment and will not be able to leave the property for any reason unless a medical emergency.
11. Curfew is 10pm on weekdays and weekends for all clients, unless on approved Leave of Absence. Being out past curfew will result in discharge.
12. Clients are required to sign in and sign out when arriving and leave the property. This is to ensure we have an accurate head count in case of emergencies and to keep track of people.
13. Client vehicles are not permitted to be parked on site.
14. Visitors must be approved by staff ahead of time, no one is permitted to show up unannounced for any reason. Do not give our address out to anyone.
15. Clients are not permitted inside of vehicles that are not associated or approved by Miklat staff. Please have the driver name and phone number on the Leave of Absence form for staff approval before entering a vehicle.

16. When walking to and from the property clients must walk in groups of no more than 3. Clients must be respectful of neighbours. This includes keeping voices down, not swearing, not wearing hoodies with the hoodie up, and keeping shirts on.
17. No smoking on organized walks around the neighbourhood. If you are out on a Planned Leave of Absence please do not smoke within a 10-minute walk of the house, this includes standing at the bus stop. Out of respect for the neighbourhood and fire safety please do not throw cigarette butts on the ground. Extinguish the tip and dispose of safely in a garbage can or ashtray.
18. Smoking and Vaping are permitted ONLY in the designated smoking area. Never smoke or vape in the house, the front yard, grass area of back yard, or garage. The ONLY designated area is in the backyard, down the ramp, in the benched in area on the concrete slab. Use the butt cans.
19. Cellphones are only permitted after complete removal of all restrictions. If a client is caught with a cell phone while on restrictions, the phone will be confiscated until restrictions are off. If you are off restrictions do not allow other clients to use your phone.
20. The following items are not permitted in Miklat House. Pornography of any kind, video games, energy drinks, pre-workouts, steroids, stimulants, protein powder that contains anything stimulating, lottery tickets of any kind, gambling chips, weapons, candles, unapproved medications, stereo systems, clothing that advertises or glorifies drugs, alcohol, or pornography of any kind. These items will be confiscated until program completion.
21. We are not a correctional institution; therefore, jail mentality or language will get you discharged. Respect your fellow clients.
22. Food is to be consumed in the dining area only. Snacks may be consumed in the living room area but please be tidy and mindful of the other clients and clean up after yourself.
23. Meals are prepared by professional chefs/cooks. If you have an appointment or other commitment and need a meal held, please contact the staff on kitchen duty.
24. Clients are not permitted in other client's rooms. If you are caught in another client's room without staff permission, you may be discharged.
25. Do not put anything on walls. No pictures, photos, posters, TAC's, tape, plastic hooks, etc.
26. Laundry Room has signs, please learn the day, which you are allowed to do laundry and use laundry facility only on that day. Please empty lint traps and make sure you do not overfill the machines with laundry.
27. If you chose to leave our facility or you are discharged, belongings must be collected within 7 days. After 7 days, items will be considered abandoned and may be distributed to other clients in need.

28. Please do not bring valuables to Miklat House; there is no secured storage for valuables. Miklat accepts no liability for lost or stolen items including money or jewellery that clients possess. You accept the risk if you bring them on our property.
29. Clients cannot make phone calls for first 7 days. Designated phone times are 5pm to 10pm, be mindful of what restriction level you are on as you will lose phone privileges if you break the rules.
30. TV can be enjoyed from 4pm-10pm during weekdays and 4pm-11pm on Friday night and Saturday night. Volume must be maintained at a reasonable level and rules for programming must be followed.
31. Lights out at 11pm on weekdays and 12pm on Friday and Saturday nights.

*These rules are subject to change without notice.

The following items are permitted:

Clothing you will need. *(Approx. 5-7 changes of clothes as we do laundry once weekly)*

- Bathing suit for local pool and lakes if you want to swim
- 2 Towels
- 2 pairs shoes
- Hygiene products such as shampoo, toothpaste, soap, deodorant, razors, etc.
- Photo ID
- Cigarettes
- Cell Phone (Stored until after restrictions end)
- Journals to write on
- Ear Plugs

Please DO NOT bring any of the following. They will be confiscated.

- Cologne
- alcohol-based mouthwash
- hand sanitizer
- Jewelry
- Laptops
- Tablets
- pornography of any kind
- video games, energy drinks
- pre-workouts steroids, stimulants, or protein powder that contains anything stimulating
- lottery tickets of any kind
- gambling chips
- weapons
- candles
- unapproved medications
- Stereo systems.

Do not bring clothing that advertises or glorifies drugs, alcohol, or pornography of any kind. These items will be confiscated until program completion.

Pre-Admission Medical Evaluation

1. Physician Information and Business Address *(Doctor to complete Steps 1-8)*

Please stamp with doctor's address stamp, including phone and fax numbers in the space below.

To the Physician

- The patient should not require any acute medical care at the time of admission.
- All communicable diseases should be in remission and properly medicated.
- The patient should be physically and mentally **ABLE** to participate in a residential program of intense counselling and activity.

Please **FAX** all current prescriptions for this patient to Miklat Recovery Society (Fax # 604-483-6462) prior to the intake day so that prescribed medication can be blister-packed and safeguarded when the client arrives.

- Patients cannot bring OPEN medications or OPEN over the counter medications onto Miklat property on the client's Intake Day.
 - Patients CAN bring blister-packed medications or unopened over the counter medications into the centre on Intake Day
 - If the Patient arrives with open medications, they will be confiscated and put into safekeeping until they have been discharged from the Program, as we cannot guarantee the purity of the medications.
 - Methadone/Methadose/Suboxone clients, please have prescribing doctor fill two week prescription before arrival.

2. Communicable Diseases

Has the client recently (within the last year), been tested for any of the following Communicable Diseases? If yes, any positive results?				
Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Immunized
Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Immunized
Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Treated & Cleared
HIV/Aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other Sexually Transmitted Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Treated & Cleared <input type="text"/>

3. Additional Medical History

History of Head Trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments <input type="text"/>
History of Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments <input type="text"/>
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments <input type="text"/>

4. Psychiatric History

Do you have a suspected Mental Health concern?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown <input type="text"/>
Does patient have a Psychiatric Diagnosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown <input type="text"/>
Dual Diagnosis/Comorbid Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown <input type="text"/>
Does the patient have history of suicidal ideation? Currently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, comment below <input type="text"/>

5. ALLERGIES: Please indicate if patient has any kind of known allergy or intolerances to food or drugs.

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No Known Allergies (NKA)
Intolerances	<input type="checkbox"/> Yes <input type="checkbox"/> No Known Intolerances:
Does the patient require an EPIPEN or an ANA kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do they have one? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please include details of allergies/intolerances:	<input type="text"/>

6. List of Medications *(Printout also acceptable)*

Medication	Condition	Prescribed Dosage	How long has client been taking?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

7. Methadone/Suboxone Maintenance Program

Start date was: (Approx.)	<input type="text"/>
Current dose is: (type and dose)	<input type="text"/>
Patient has been on current dose of for:	<input type="text"/>
My prescribing Physician is:	<input type="text"/>
Phone Number & Fax Number:	<input type="text"/>

- I acknowledge that I come to PR Miklat Recovery House stabilized on a Methadone/Suboxone Program.
- I acknowledge that I have an opioid use disorder and wish to continue my Methadone/Suboxone Program while at Powell River Miklat Recovery House.
- I agree that while at Miklat, I will receive my Methadone/Suboxone daily from a qualified designate.
- I agree to adhere to the program guidelines as detailed to me upon orientation to the facility.
- I understand that my failure to participate in the program outlined will result in a review of my suitability for the treatment program
- I agree to a supervised urine sample for drug screening as requested. I understand that failure to comply will result in discharge from the program
- I will take my Methadone/Suboxone, witnessed, daily, as according to the protocols.

Client Name: (print)	Client Signature:
<input type="text"/>	<input type="text"/>
Witness Signature:	Date:
<input type="text"/>	<input type="text"/>

8. Declaration of Physician – (to be completed for All Clients)

I conclude that my Patient **(IS)** physically and mentally fit and stable to fully participate in all aspects of the treatment program at Miklat Recovery Society.

I conclude that my Patient **(IS NOT)** physically and mentally fit and is unstable to attend treatment at Miklat Recovery Society.

Client Name:

DOB:

Current Date:

Physician Name:

Current Date:

Physician Comments: