SUNRISE

Native Addictions Services Society
1231 - 34th Avenue N.E., Calgary, AB T2E 6N4
(P) 403-261-7921 (F) 403-261-7945 Administration
(F) 403-269-5578 Client Admissions
(E) nasgeneral@nass.ca

SUNRISE-Native Addictions Services Society
Application for Inpatient Treatment

Date:___________________

Last Name:___________________________________ First Name:________________________________

Address:____

Phone Number:_________________

Date of birth:___________ Age:______ Sex: M______ F_______

How did you hear about us? ____

Are you: ☐ Treaty/Status ☐ Non-Status ☐ Metis ☐ Inuit ☐ Other

Band Name: _______________________________ Treaty # ___________________________

Are you a residential school survivor? YES ______ No ______

AHC#:________________________________ SIN#:_________________________

Occupation:______________________________ Employer:__________________________

Marital Status:_________________________

Number of Children (Less than 18 years old) and ages: _______________________________________

Next of kin or person(s) to be notified in case of emergency:

Name:_______________________________ Phone Number:______________________________

Address:____

Relationship to Applicant:____

Are you mandated by Child and Family Services to attend treatment: YES ______ No ______

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Primary Addiction: ________________________ When did you start and how often do you use/drink/gamble etc? _____________________

Secondary Addiction: ______________________ When did you start and how often do you use/drink/gamble etc? _____________________

Please provide any details regarding previous treatment experience for Alcohol/Drug/Gambling dependency: ____

1) Please indicate what you are hoping to achieve through attending our program and 2) on a scale of 1-10 how committed are you to your own recovery at this time. (1 low commitment – 10 very high commitment):____

____

Have you ever been **diagnosed** with a Mental Health concern (i.e., depression, anxiety, bipolar disorder, personality disorder, etc.) YES ____ No ____. If Yes, what?_________________________

If yes, are you currently on any medications to treat the disorder? Please list name of medication(s):____

Are you aware of any family member who is employed by Native Addictions Services or is currently a client? YES ______ No ______

Is this your first visit to NAS and/or Sunrise: YES ______ No ______

Are you currently feeling suicidal or have you had a recent suicide attempt? YES ______ No ______

- **Sunrise is NOT a medical facility and has NO medical staff on site. By initialing here the client acknowledges and understands the forgoing. Initial ___________.**

Please describe your situation in the following areas:

1. Family Relationships:

____

____

____

____

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2. Employment (Regular type of work, employment status etc.)

____

____

____

3. Social (groups, activities, friends, etc.)

____

____

____

4. Legal/Past and Pending Charges/Upcoming Court Dates/Parole/Probation/Mandated to Treatment) – Please list all past and pending charges and court dates:

____

____

____

5. Family Addictions History:

____

____

____

6. Financial (Source of income, debts. etc)

____

____

____

Do you have housing after treatment? YES ______ No ______

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Staff Member's Signature: ______________________________

Applicant's Signature: ____

Please note: **Sunrise Native Addictions Services reserves the right to refuse admission to clients it deems inappropriate for its programs.**

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Confidential Inpatient Treatment Medical Form

It is a requirement of Sunrise Native Addictions Services Society that any client seeking admission to this facility must present a recent medical examination. This form should be filled out by a Doctor/RN and included with the client's application for admission.

Applicant's Name: ____

Alberta Health Care Number: ____

Client's Consent to Release Information:

I, ________________________________ (client's name) hereby consent to the release of my medical assessment contained in this questionnaire to SUNRISE – Native Addictions Services Society.

________________________________ ________________________

Client or Applicant's Signature: Date:

Doctor/RN Name: ____________________ Phone Number: ______________________

Address: ____

Are you the applicant's regular Doctor: YES ☐No ☐

Certain medical conditions and/or surgeries may restrict the client's participation in the treatment program. Please indicate whether this applicant has a history of any of the following:

Cancer		**Sexually Transmitted Disease**	
Epilepsy		**Heart Disease**	
Diabetes		**Tuberculosis**	
Allergies		**Respiratory Problems**	
Rheumatic Fever		**Hallucinations**	
Visual Problems		**Audio Problems**	
Alcohol/Drug Related Seizures		**Arthritis**	
Hepatitis/Liver Disease		**Kidney Disease**	
Pressure Ulcers		**VTE (Venous thromboembolism)**	
Skin or Wound Care Necessary		**Recent Surgery**	
Other: please specify			

Please give details of any of the items checked above. (Use the other side of this page, if necessary)

Tuberculosis Symptom Inquiry – does this applicant present with any of the following symptoms:

☐ cough ≥ 3 weeks (productive) ☐ fever

☐ night sweats ☐ weight loss

☐ fatigue ☐ hemoptysis

If symptoms suggest active TB disease, chest x-ray and sputum samples for AFB and culture are recommended and possible referral to Tuberculosis Services 403-944-7660

Influenza Symptom Inquiry – Does this applicant present with any of the following symptoms:

☐ symptoms of fever ☐cough ☐ runny nose

☐ sore throat ☐ body aches ☐ fatigue

☐lack of appetite ☐ diarrhea ☐ vomiting

If symptoms suggest active influenza please direct the client for proper treatment. Clients must be symptom free to attend our Inpatient Treatment Program.

Psychological/psychiatric conditions might interfere with participation in the treatment program. Are you aware of any peculiarity or problems (i.e.: extreme anxiety, psychosis, depression, suicide attempts, etc.) that should be taken into account during treatment. Please detail:

____

Please List all Drug and Food Allergies:

____

Current Medications	Prescribed by	Date Prescribed	Duration and Reason Prescribed

If the client needs a refill for any of their medication it will assist the client and SUNRISE if they come to treatment with a prescription or all of their needed medications. They may not be allowed to attend treatment should they not arrive with all their medications or a prescription in hand.

I certify the above to be true to the best of my knowledge:

______________________________________ _____________________________

Doctor/RN Signature **Date**