



# Sunrise Healing Lodge

1231 - 34th Avenue N.E., Calgary, AB T2E 6N4  
(P) 403-261-7921 (F) 403-261-7945 Administration  
(P) 403-269-5567 (F) 403-269-5578 Client Admissions  
(E) admissions@nass.ca

## Sunrise Healing Lodge Society Application for Inpatient Treatment

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Homeless? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Can Sunrise leave a message at this number? \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender Identity: Male \_\_\_ Female \_\_\_ Non-Binary \_\_\_ Intersex \_\_\_ Two-Spirited \_\_\_

How did you hear about us? \_\_\_\_\_

Are you:  Treaty/Status  Non-Status Aboriginal  Métis  Inuit  Other

Band Name: \_\_\_\_\_ Treaty #: \_\_\_\_\_

Do any of the below pertain to you:

Residential School  Sixties Scoop  Day School  Indian Hospital

Alberta Health Care #: \_\_\_\_\_ (REQUIRED FOR TREATMENT)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_

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

Where do your children live and with who? \_\_\_\_\_

Are you **mandated** by Child and Family Services (CFS) to attend treatment: YES \_\_\_ NO \_\_\_

Are Child and Family Services involved with your family? \_\_\_\_\_

CFS Worker Name AND Phone Number: \_\_\_\_\_

**Primary Addiction - Please pick ONE:**

- Alcohol
- Amphetamine
- Other stimulants
- Cannabis
- Cocaine/Crack
- Gabapentin
- Hallucinogens
- Heroin
- Fentanyl
- Prescription Opioid
- Hypnotics/Sedatives
- Inhalants/Solvents
- Other, please explain: \_\_\_\_\_

When did you start and how often do you use/drink/gamble etc? \_\_\_\_\_

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**Secondary Addiction- Please check off all other substances used:**

- Alcohol
- Amphetamine
- Other stimulants
- Cannabis
- Cocaine/Crack
- Gabapentin
- Hallucinogens
- Heroin
- Fentanyl
- Prescription Opioid
- Hypnotics/Sedatives
- Inhalants/Solvents
- Other, please explain: \_\_\_\_\_

When did you start and how often do you use/drink/gamble etc? \_\_\_\_\_

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Please provide any details regarding previous **treatment** experience for  
Alcohol/Drug/Gambling dependency, list dates of attendance and completion:

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Factors that have contributed to your need for Addictions Treatment- Select any that apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abuse/Violence             | <input type="checkbox"/> Impulse Control      | <input type="checkbox"/> Personality     |
| <input type="checkbox"/> Acting Out/Antisocial      | <input type="checkbox"/> Legal                | <input type="checkbox"/> Relationships   |
| <input type="checkbox"/> Addiction (not substances) | <input type="checkbox"/> Medical              | <input type="checkbox"/> Self-Harm       |
| <input type="checkbox"/> Cognitive                  | <input type="checkbox"/> Mood                 | <input type="checkbox"/> Gender Identity |
| <input type="checkbox"/> Crisis                     | <input type="checkbox"/> Neurodevelopmental   | <input type="checkbox"/> Sleep           |
| <input type="checkbox"/> Developmental              | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Social          |
| <input type="checkbox"/> Eating                     | <input type="checkbox"/> Other Mental Health  | <input type="checkbox"/> Trauma/Stress   |

1) Please indicate what you are hoping to achieve through attending our program and detail your level of commitment to your recovery:

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Have you ever been **diagnosed** with a Mental Health concern (i.e., depression, anxiety, bipolar disorder, personality disorder, etc.) YES \_\_\_\_ NO \_\_\_\_

If Yes, what and when were you diagnosed? \_\_\_\_\_

Are you currently on any medications? If yes, please list name of ALL medication(s):

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Are you currently having thoughts of suicide or self-harm, or have you had past suicide attempts?

YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please explain when: \_\_\_\_\_

Are you aware of any family member who is employed by Sunrise Healing Lodge or is currently a client? YES \_\_\_\_\_ NO \_\_\_\_\_

Is this your first visit to Sunrise: YES \_\_\_\_ NO \_\_\_\_

If YES, when did you attend Sunrise? \_\_\_\_\_ Inpatient or Outpatient? \_\_\_\_\_

Sunrise is NOT a medical facility and has NO medical staff on site. By initialing here, the client acknowledges and understands the foregoing. Initial \_\_\_\_\_

Sunrise is a trauma-informed facility, NOT a trauma-focused facility. Sunrise does not have psychologists available to clients. By initialing here, the client acknowledges and understands the foregoing. Initial \_\_\_\_\_

**Please describe your situation in the following areas:**

**1. Family/Social Supports:**

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

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**3. Legal: Disclosure of ALL legal history and ALL past/pending charges is a REQUIREMENT to attend treatment:**

**a. Do you have current criminal charges? If yes, please list below in DETAIL:**

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**b. Do you have past criminal charges? If yes, please list below in DETAIL:**

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**c. Do you have upcoming court dates? If yes, please list below. Attendance at court/trial will not be permitted while attending Sunrise.**

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**d. Are you on probation, parole, or bail? If yes, please list below. Probation Order/Release Papers/Conditions MUST be provided to Sunrise prior to treatment approval.**

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**Probation/Parole Officer Name and Phone Number: \_\_\_\_\_**

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**5. Family Addictions History:**

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**6. Income Source- Please check all that apply:**

- Employment
- Alberta Works, please list Alberta Works File # \_\_\_\_\_
- AISH
- Employment Insurance (EI)
- On-Reserve Income Assistance
- Other assistance or source of income
- No income

Do you have safe and stable housing for after treatment? YES \_\_\_\_\_ No \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_

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

**Full Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Relationship to**

**Applicant:** \_\_\_\_\_

**Please note: Sunrise Healing Lodge reserves the right to refuse admission to clients it deems inappropriate for its programs.**

**CONSENT FOR RELEASE AND COLLECTION OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, give permission to **Sunrise Healing Lodge** to contact:  
 PRINT NAME

TO/FROM (Please check only those that you have involvement with)	<input type="checkbox"/> Alberta Health Services <input type="checkbox"/> Calgary Drug Treatment Court <input type="checkbox"/> Calgary Probation and Community Corrections <input type="checkbox"/> Corrections Service Canada <input type="checkbox"/> Calgary Police Service or POET <input type="checkbox"/> Alberta Works <input type="checkbox"/> First Nation Inuit Health Branch (FNIHB), Medical Transport (NIHB) <input type="checkbox"/> Assured Income for the Severely Handicapped (AISH) <input type="checkbox"/> Child and Family Services <input type="checkbox"/> Elizabeth Fry Society and John Howard Society <input type="checkbox"/> Oxford House <input type="checkbox"/> Other: _____
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WHAT INFORMATION	For the purposes of arranging funding for treatment, transportation to/from treatment, medical assessment for treatment, housing for pre-treatment, and status of criminal charges, probation or parole to assess appropriateness for treatment.
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CONSENT	I understand that provision of treatment services is not entirely dependent upon my decision to release information and that I may cancel this consent at any time. I also understand that some action may have been taken prior to cancellation. Client Signature: _____  Witness: _____ Date signed: ____/____/____ Permission will expire on ____/____/____/
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CANCEL	I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation. Client Signature: _____ Witness: _____ Date Signed: ____/____/____
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## **Medication Policy for Admissions**

Sunrise reviews the medication requirements and medical needs of all potential clients prior to admission. Should Sunrise staff require additional information, potential clients must agree to sign a Release/Receipt of Information for their doctor, mental health professional, or others as necessary.

Under no circumstances are Sunrise clients permitted to take **opioids, opioid replacements, benzodiazepines, barbiturates/sedatives, medications for cravings or sleeping aids** while at Sunrise. **All other medications will be considered on a case-by-case basis.** Certain medications (stimulants/gabapentin) may require additional doctor notes to be permitted. Clients are not to **start** any mood-altering medication while in the care of Sunrise. Potential clients who take medication must be stable on this medication for a minimum of **4 weeks** prior to admission.

**ALL medications/vitamins must be prescribed and deemed medically necessary.**

Sunrise Healing Lodge does not have medical staff on site; all potential clients **MUST** take care of their health and medication needs prior to admission.

**Sunrise reserves the right to deny any potential client admission to the Inpatient or Outpatient programs based on medication or medical needs.**

I, \_\_\_\_\_, of my own free will, without duress or undue influences  
(Applicant's Name)  
hereby give permission to Sunrise Healing Lodge Society to release/receive relevant, confidential information written or oral to - from **Blue Bottle Pharmacy** for the purpose of my application to attend treatment. This authorization shall legally remain in effect until cancelled by myself in writing or after **a period of 2 years** from the date this form is signed.

\_\_\_\_\_  
Applicant Date of Birth

\_\_\_\_\_  
Alberta Health Care #

\_\_\_\_\_  
Applicant Name (PRINT)

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Prescription Coverage Information

\_\_\_\_\_  
Current Pharmacy Name and Phone Number

\_\_\_\_\_  
Date

## Sunrise Healing Lodge Confidential Inpatient Treatment Medical Form

It is a requirement of Sunrise Healing Lodge 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 be included with the client's application for admission.

Applicant's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ 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 Healing Lodge Society. I also give permission for Sunrise and staff to contact the below medical professional should further medical information be required for my admission to the Sunrise program.

Client or Applicant's Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

Doctor/RN Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_

Are you the applicant's regular Doctor: YES  NO

Certain medical conditions 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			



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

- cough  $\geq$  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 that might interfere with participation in the program.** Are you aware of any conditions (i.e.: extreme anxiety, psychosis, depression, suicide attempts, etc.) that should be taken into account during treatment. Please detail:

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Please List all Drug and Food Allergies:

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Specialized Diet Requirements (vegeratian/gluten-free, etc.): If YES, please explain:

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Current Medications	Prescribed by	Date Prescribed	Duration and Reason Prescribed

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

\_\_\_\_\_  
Doctor/RN Signature

\_\_\_\_\_  
Date

## Sunrise Healing Lodge Important Information for Clients (Please keep for your information – Do not send back)

### Application:

Please ensure your application includes your medical assessment. After your application is sent in **please allow 3 business days for processing**. Once your application has been approved and there is a bed available, we will give you a confirmation date and send you the Sunrise Inpatient Client Handbook with all pertinent details for your admissions day. **If there is a wait list, you are responsible to call the Admissions Coordinator weekly to check in – you can leave a message. If you do not check in, your name will be removed from the waitlist.** Sunrise keeps applications on file for 3 months, after 3 months, both the application and medical are shredded.

### Appointments:

**All legal, medical, employment, housing and child-care appointments must be dealt with prior to admission. Clients will not be allowed to attend outside appointments/court dates while in the Inpatient Program.**

### Financial Information

- If you do not have an Alberta Health Care Number and are paying room and board fees personally, Sunrise will only accept money orders or certified cheques. Please have a bank draft or money order made out to Sunrise Healing Lodge Society prior to admission.
- If coming from out of province, Room and Board fees are your responsibility. You can access funding through First Nations Inuit Health Branch/Employee Benefits - if eligible. If you are being mandated to treatment, please have your worker approve funding prior to admission in writing.
- Do not bring in large amounts of cash - only bring enough to get by (for bus tickets/tobacco). We will not hold money for clients and are not responsible.

### Other Information:

- Sunrise is an abstinence-based program, **you MUST be 3 days (72 hours) sober off of ALL substances (including medical marijuana)** before your admission date. Please let the Admissions Coordinator know if you cannot stay sober on your own and if you need, a referral to detox can be made.
- We are a smoking facility, smoking is allowed outside of the centre in designated areas, and during specific times. Please bring at least 2 weeks worth of tobacco.
- Treatment groups run 7 days a week. It is **mandatory** for you to attend all groups, including 12 Step meetings and Cultural activities.
- Visiting hours are on Saturdays only. The hours are 1:00pm to 9:00pm for adults and 1:00pm to 6:00pm for children.
- **All medications must be approved by your doctor and Sunrise prior to admission.** Only bring in medications listed on your Admissions Medical unless you have approval from the

Admissions Coordinator. Medications are only admitted in their original packaging with **original labels**.

- Any vitamins **MUST** be prescribed and have a prescription label, no exceptions.
- No powder supplements (protein/collagen) permitted.

**\*\* Once you are on the wait list or have a start date, here is a general list of what to bring:**

**(2 large bag maximum)**

- Bus Pass or bus tickets (required to attend outside 12 Step meetings)
- Shampoo, Conditioner, Soap
- Deodorant and other Personal Hygiene/ Care Items
- Tooth brush and toothpaste
- Alarm clock
- Slippers, Moccasins, Clothes according to season
- Tobacco - Enough for two weeks minimum
- Phone card for long distance phone calls
- Pen/pencils and paper