Shunda Creek Recovery Centre

Pre-Admission Package

Please review the following criteria to ensure viability for the program before applying.

- 18-26 years old male
- Alberta resident with an active provincial healthcare number.
- Physical ability to engage in wilderness-based activities.
- Stable on medications with no medications that are on the restricted medication list (atached).

The following forms make up the application package. Please ensure you have completed and enclosed all the items listed below. If an incomplete application is received the application will be placed on hold until all forms are submited.

- Application Form- Completed by Applicant – 3 pages
- Medical Form- Completed by a Physician - 7 pages
- Physician's Information Form- **Physician signature required**

Shunda Creek, in partnership with Recovery Alberta, uses My Recovery Plan for wait list management. By completing the following application, you are consenting to the collection or personal information (ie: name, DOB, contact info, gender, substance use history and housing status) to be put on the wait list for addiction treatment. Recovery Alberta uses My Recovery Plan to electronically manage your personal information on the wait list.

Please note that 2-4 pre-admission sessions will be completed via virtual or telephone appointments. Please include an active phone number to reach the applicant.

If you need any support completing your application, or have any questions related to the program or eligibility, please contact the Shunda Creek Intake Coordinator at 403-826-3692 or 403-200-6595

Submit your complete application package to the Shunda Creek Intake Coordinator via:

Email – shundaintakecoordinator@enviros.org

The applicant will be contacted within 2-4 business days to set up their first virtual appointment. Shunda Creek Recovery Centre is a fully funded program, there is no cost to atend.

ENVIROS

Program Application

Client Information			
Last name	First name	Birth date *(yyyy-Mon-dd)*	Age
Address	Mailing Address		
City / Postal Code		Phone Number	Alternative Phone Number
Alberta Health Care #	Gender Please Select	Marital Status	
Are you pregnant? ☐ No ☐ Yes ► Due date *(yyyy-Mon-dd)* _____ Have you received prenatal care? ☐ No ☐ Yes			Do you have children? ☐ No ☐ Yes
Do you have any special needs? ***(Reading/writing English, Wheelchair accessibility, hearing difficulties, etc.***			
Cultural Identity: The following question is asked in order to improve its services to individuals from a variety of cultural/ ethnic backgrounds. If you identify yourself with a particular ethnic or cultural group(s), please tell us which one(s). ☐ Specify _____ ☐ I do not identify with any ethnic or cultural group.			
Indigenous ☐ Treaty status ☐ On-reserve ☐ Off- reserve ☐ Metis ☐ Non-Status ☐ N/A Treaty No. *(10 digits)* _____ Band Name _____			
Emergency contact/Next of Kin *(Last name, First name)*			
Relationship to you		Phone Number	Alternate Phone Number
Where will you live after treatment?			
Referring Worker *(Last name, First name)* ☐ Self-Referral			
Referring Office *(Name)*			
Phone Number	Fax Number	Other	

ENVIROS

Program Application

Education/Employment History

Last grade/college level completed

☐ None ☐ Junior High ☐ Some High School ☐ Graduated High School

☐ School/Labour Ticket ☐ College/Tech.Diploma ☐ University Degree

Are you considering further education?

_____

What is your current income status?

☐ Unemployed ☐ Employed Part-time ☐ Employed Full-time ☐ Student

☐ Self-employed ☐ Disability ☐ Government ☐ Other

Legal Involvement/History or Trauma or Violence

Are you attending this treatment under any of the following conditions

☐ Probation ☐ Temporary Absence ☐ Court Order ☐ Drug Court ☐ Statutory Release

☐ Out on bail ☐ Own recognizance ☐ Child and Family Services conditions ☐ Employer

If attending treatment due to legal involvement, what is the offense?

_____

_____

List of conditions

_____

Do you have any upcoming court dates, community service hours, or are you on a parole or probation, etc.

_____

Probation Officer or Child and Family Services worker *(Last name, First name)* ☐ Consent to Contact

Phone Number	Fax Number

Do you identify with a history of trauma? ☐ No ☐ Yes

Domestic violence ☐ No ☐ Yes

Sexual violence ☐ No ☐ Yes

Have you ever become aggressive or have history of violence in/with

☐ Intimate relationships ☐ Friends/acquaintances ☐ Work relationships ☐ Animals

☐ Strangers ☐ Relatives ☐ Other drivers on the road

Do you have a history for illegal fire starting? ☐ No ☐ Yes

ENVIROS

Program Application

Substance Use/Gambling History

Other addiction to concerns?

☐ Video games/TV ☐ Sex/Pornography ☐ Food ☐ Gambling

☐ Shopping ☐ Relationships ☐ Other _____

Tobacco use

Do you smoke or use smokeless tobacco? ☐ No ☐ Yes

Are you interested in quitting while in treatment? ☐ No ☐ Yes

N**ote:** Shunda Creek is a tobacco free site

What are the most important areas for you to address in treatment?

_____

_____

Are your family and/or significant others involved in your treatment? ☐ No ☐ Yes

Is your family aware of the opportunities for involvement? ☐ No ☐ Yes

Will your family be attending the family component of the program? ☐ No ☐ Yes

What would stop your family or significant other from being involved?

_____

_____

Medical Health Information *(Medical form to be completed by Physician)*

Medications (*prescription and over the counter*) being used (*please provide information about what the medication is prescribed for, frequency of us, etc.*)

_____

_____

_____

_____

_____

_____

If prescriptions are required, how will they be paid for? (SFI client #, Blue Cross, etc.)

_____

_____

_____

_____

_____

_____

Are there any physical limitations that would prevent you from participating in treatment programming?

_____

_____

_____

_____

PHYSICIAN INFORMATION

_____ has applied to enter into a 12 week addiction recovery program provided by Enviros Wilderness School Association. The wilderness based program is located in the Shunda Creek area east of Nordegg Alberta. As a wilderness based program, treatment is delivered individually and in group settings at the camp site as well as in the wilderness. As part of treatment _____will be expected to participate in a variety of recreational and wilderness activities. These activities are not designed to be extreme; however, a reasonable level of health and ability is required to participate.

_____may be exposed to situations and environmental conditions where the stresses and hazards may be greater or different than those normally encountered. Activities that may be utilized while in an Enviros Wilderness School Association program may include, though are not limited to day hiking, multi-day backpacking trips, top roped climbing (indoor, rock and ice), canoeing (lake and river), rafting, cross-country and downhill skiing, experiential activities, low and high ropes courses, swimming, and mountain biking.

Please take this in to consideration when you assess _____as part of his treatment application.

Physician, please sign as read and return with completed medical form.

Physician Signature: _____ Date: _____

(dd-mmm-yy)

Print Name: _____

Respectfully,

Enviros
Shunda Creek
403-721-3918

Shunda Creek Recovery Centre
Restricted Medications List

The following medications are restricted at Shunda Creek Recovery Centre
*(Note: this list is not exhaustive and other medications may be subject to restriction) *

Opioid Pain Medications

- Morphine (e.g. Kadian)
- Fentanyl
- Hydromorphone (Dilaudid)
- Oxycodone (Percocet, OxyNeo)
- Meperidine (Demerol)
- Codeine & Codeine products (e.g. Tylenol #3)
- Tapentadol (Nucynta)
- Pentazocine (Talwin)
- Propoxyphene (Darvon)
- Tramadol (Zytram, Ralivia, Triural)

Benzodiazepines

- Alprazolam (Xanax)
- Bromazepam (Lectopam)
- Lorazepam (Ativan)
- Oxazepam (Serax)
- Temazepam (Restoril)
- Triazolam (Halcion)
- Clonazepam (Rivotril, Klonopin)
- Chlordiazepoxide (Librium)
- Clorazepate (Tranxene)
- Diazepam (Valium)
- Nitrazepam (Mogadon)
- Flurazepam (Dalmane)

Sedatives/Hypnotics/Sleeping Medications

- Secobarbital (Seconal)
- Chloral Hydrate (Aquachloral, Chloralum, Somnote)
- Ethchlorvynol (Placidyl)
- Glutethimide (Doriden, Elrodorm, Noxyron, Glimid)
- Methyprylon
- Zopiclone (Imovane, Zimovane)
- Eszoplicone (Lunesta)
- Zaleplon (Sonata)
- Zolpidem (Ambien)

Other Substances

- Synthetic Cannabinoids (Nabilone/Cesamet, Dronabinol/Marinol)
- Cold Medications (Decongestants, anti-cough meds)
- Electronic cigarettes
- Tobacco products
- THC, CBD, CBG products

Psychostimulants- At Shunda Creek we recognize that the use of Psychostimulant medication for ADHD management can be a valuable tool for recovery. Therefore, we will allow the following medications if clients have been stable at a maintenance dose for at least 6 weeks.

- Dextroamphetamine (Dexedrine)
- Amphetamine mixed salts (Adderall XR)
- Lisdexamfetamine (Vyvanse)
- Methylphenidate (Ritalin, Biphentin, Concerta)

Med Changes & Stability

All participants will need to be stable on medications for six weeks prior to entering the Shunda Creek Recovery Centre. We are unable to accommodate medication changes during your 90 day treatment. If dose or type of medication needs to be changed while in program a treatment leave will be arranged to do so in your home community.

What if I am taking Methadone or Suboxone for opioid dependence treatment?

Sublocade and Suboxone are accepted at Shunda Creek Recovery Centre. Clients will need to be stable at their maintenance dose for at least 1 week prior to intake. The preadmission counsellors will work with ODP clinics to ensure the prescription is in place for the 90 day treatment cycle.

What about Vitamins and Supplements that support my recovery?

Vitamins (i.e. vitamin B) and supplements (i.e. melatonin) can only be used with a Dr's prescription. The product must be brought to treatment in a sealed container. Please ensure you have enough to cover the 90 days in program.

What if I am currently on a restricted Medication?

• With physician guidance and supervision, you may be able to discontinue the medication for the duration of your treatment. We suggest making a plan with your physician to taper off any medications.

• You can request from your physician an alternative medication that is not on the restricted medication list.

Please note that any medication changes require a 6 week stabilization period prior to intake

ENVIROS

Medical Assessment

There is **no cost to completing this medical.**

Last Name	First Name		
Personal Health Care number			Phone
Family Physician's *(Last name, First name)*			Phone
Are you the applicant's regular Physician? ☐ No ☐ Yes			
Date of last examination *(yyyy-Mon-dd)*	Date for follow up *(yyyy-Mon-dd)*		
Does this person have or has he/she ever been treated for	**No**	**Yes**	**Please elaborate re: impact on current functioning.**
Loss of consciousness or coma	☐	☐	
Frequent, chronic or severe headaches	☐	☐	
Blackouts	☐	☐	
Head injuries/serious falls/car accident	☐	☐	
Childhood/adult illness-high fever/serious infection	☐	☐	
Epilepsy *(seizures)*	☐	☐	
Dizzy spells	☐	☐	
Allergies/Asthma - please indicate specifics *(What/Severity/Treatment).*			
Sleeping disorders	☐	☐	
Heart disease or heart problems	☐	☐	
Stroke	☐	☐	
Tumors	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Abdominal or stomach problems	☐	☐	
MRSA	☐	☐	
Back problems/joint problems	☐	☐	
Skin disorders	☐	☐	
HIV	☐	☐	
Hepatitis	☐	☐	
Sexually transmitted infections/ Last tested?	☐	☐	
Lung conditions/respiratory problems	☐	☐	
Does applicant smoke?	☐	☐	Can a prescription NRT be Provided?
Glasses/contact lenses/visual problems	☐	☐	
Hearing impaired	☐	☐	
Presence of/exposure to communicable disease	☐	☐	
Any other medical conditions/symptoms	☐	☐	
Pain ☐ acute ☐ chronic	☐	☐	
Pregnancy	☐	☐	
Addiction or substance abuse/ever use IV drugs	☐	☐	
If yes Comments			
Has applicant been hospitalized in the last year?	☐	☐	
If hospitalized, please list dates, reasons, length of stay.			

Physician's Initial: _____

ENVIROS

Medical Assessment

Psychiatric History

Has this patient ever seen a psychiatrist? ☐ No ☐ Yes ▶ Who _____

When *(Date yyyy-Mon-dd)* _____

Diagnosis	Treatment

Are any of the following present?

Delusions/Hallucinations ☐ NO ☐ Yes ▶

Confusion/Disorganized Behaviours ☐ NO ☐ Yes ▶

Suicide Risk/Attempts ☐ NO ☐ Yes ▶ When*(Date yyyy-Mon-dd)*

Method _____

Treatment Provide ☐ No ☐ Yes

Are any of the following sufficiently impaired to interfere with emotional or cognitive functioning?

Memory	☐ No	☐ Yes	Attention	☐ No	☐ Yes	Concentration	☐ No	☐ Yes
Impulse Control	☐ No	☐ Yes	Verbal Skills	☐ No	☐ Yes	Abstract Thiking	☐ No	☐ Yes
Judgment	☐ No	☐ Yes						

Comments

Medications ***(Complete if Addictions Counsellor don't have access to the Netcare (Medication Reconciliation)***

Name	Prescribing Doctor	Dose/frequency	How long has patient been on this medication? Date Prescribed *(yyyy-Mon-dd)*	As treatment for what?

Physician's Initial: _____

ENVIROS

Medical Assessment

Restricted Medications *(If a restricted medication is recommended by a physician for a compelling medical reason, each site will consider on a case-by-case basis. a signed Physician letter must be included with this form for any exceptions)*				
Name	Prescribing Doctor	Dose/frequency	How long has patient been on this medication? Date *(yyyy-Mon-dd)*	As treatment for what?
Comments/Potential Side Effects				
Medication Taper Plan				
If you are aware of any concerns/issues that should be taken into account in the treatment of the applicant, please indicate and give details				
Comments				
Physician's Signature		Date *(yyyy-Mon-dd)*	Physician's Stamp	

Physician's Initial: _____

ENVIROS

Program Application Young

Mental Health Information
Use Mental Health Assessment, as per Zone
Do you have any history of self-harming behaviours, including cutting? ☐ No ☐ Yes ▶ provide information, such as how current the thoughts or behaviors are
Do you have a history of restricting food intake or binging and purging? ☐ No ☐ Yes ▶ provide information, such as how current the thoughts or behaviors are
If currently under the care of Psychiatrist/Psychologist

Last Name	First Name	Phone
Previous psychological assessment attached ☐ No ☐ Yes		
Referring Person *(Last name, First name)*	Signature	Date *(yyyy-Mon-dd)*

Physician's Initial: _____