RE:ACT Recovery Education for Addictions and Complex Trauma

RULES:

Thank you for your interest in **RE:ACT** (Recovery Education for Addictions and Complex Trauma). Prior to submitting your application, we require you to read the following program policies. In order to be admitted into this program, these policies must be agreed to by you.

1. Clients are expected to attend all scheduled activities including, but not limited to: classes, one-on-one counseling, group counseling.

2. Clients may be asked at any time in the program to provide a urinalysis or a medical check-up. Clients will provide a urinalysis during the intake process.

3. Clients displaying a poor attitude towards program, aggressive or violent behaviour, or disregard for the rules, may be discharged. This includes violence of any kind (verbal or physical) to any participant or staff in the building.

4. If placed on the wait-list, I will check-in with the intake counselor once per week.

I admit that I have an addiction and/or trauma and request that I be accepted into **RE:ACT** for the sole purpose of dealing with addiction and/or trauma. I have read the above outlined description of the program and I am willing to abide by all program rules and meet all program expectations and to actively participate in all aspects of the program. I understand that failure to do so will result in my being asked to leave the program.

Date: _____

Client Name: _____

Signature: _____

257 RIVERTON AVENUE
WINNIPEG, MANITOBA
R2L 0N2

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION:

I hereby authorize **RE:ACT** (Recovery Education for Addictions and Complex Trauma) to release and/or obtain information from the following agencies/persons listed below:

I recognize that information may be shared, as required, with other team members and programs within **RE:ACT**. In addition, confidential information will be shared without written consent if child abuse is suspected, records are subpoenaed, or clients are felt to be a threat to their own or another individual's health and/or safety.

I hereby waive any and all claims against **RE:ACT**, employees and agents for all purposes whatsoever arising from the disclosure of this information.

Date: _____ **Client Name:** _____

Signature: _____ **Staff Signature:** _____

Assessment Date:

☐ Accepted ☐ Delayed Intake ☐ Referred ☐ Denied

Assessment Notes:

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GENERAL INFORMATION:

Full Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Age: _____

Phone number: _____

Address: _____

_____

Relationship Status: ☐ Never Legally Married ☐ Legally Married

☐ Separated, but still Legally Married

☐ Divorced ☐ Widowed

Do you have kids? ☐ Yes ☐ No How many? _____

Which Phase(s) in our Program are you interested in attending?

☐ Phase One ☐ Phase Two ☐ Ongoing Healing Program

Emergency Contact: _____ Relationship to you: _____

Emergency Contact's Phone Number: _____

Welfare/Social Assistance Case number: _____

Welfare Worker: _____

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LEGAL INFORMATION:

Are you involved with CFS? ☐ Yes ☐ No

CFS Worker: _____

Do you have a visitation schedule with your kids? _____

Has CFS required you to go to treatment? _____

Have you ever been arrested? _____

Please list ALL pending charges: _____

_____

Please list ALL past charges: _____

_____

Upcoming court dates: _____

Do you have an NCO against anyone? ☐ Yes ☐ No

Or does anyone have an NCO against you? ☐ Yes ☐ No

If so, who? _____

Have you ever had any gang affiliations? Past or current? _____

Are you currently in jail? ☐ Yes ☐ No

If so, which one? _____

When is your expected release date? _____

Are you on Probation or Parole? ☐ Yes ☐ No

Probation/Parole officer: _____ Phone number: _____

Lawyer: _____ Phone number: _____

DRUG/ALCOHOL HISTORY:

Are you currently in detox? ☐ Yes ☐ No

Are you currently in another treatment program? ☐ Yes ☐ No

Have you ever completed detox or another program? ☐ Yes ☐ No

When? _____ Which ones? _____

First drug of choice: _____

Second drug of choice: _____

Third drug of choice: _____

When was the last day that you used? _____

Do you have issues with gambling? ☐ Yes ☐ No

Why are you wanting treatment now? _____

MEDICAL INFORMATION:

Name of Family Doctor: _____

Clinic: _____ Phone number: _____

Please list ALL current medication: _____

Do you have any medical concerns? ☐ Yes ☐ No

Have you ever been diagnosed or treated for Mental Health? ☐ Yes ☐ No

Mental Health Worker/Psychiatrist: _____

Phone Number: _____