Cardinal Recovery Homes Application

Check the Recovery Home you are applying for?

- ☐ North Battleford Recovery House
- ☐ Swift Current Recovery House
- ☐ Yorkton Recovery House

Name of Completed Addiction Treatment (if applicable):

Location: | Completion Date: | Sobriety Date:

Legal Last Name: | **Legal First Name:** | **Middle Name:**

Other Name(s) Used, First and Last:

Date of Birth (YYYY-MM-DD) | Health Care Number: | Age:

☐ Male ☐ Female ☐ Other:

Mailing Address: | City/Town:

Province: | Postal Code:

No fixed address (please specify which City you reside in)

Primary Phone: | Email:

Ethnicity

- ☐ Status ☐ Métis ☐ Non-Indigenous
- ☐ Non-Status ☐ Inuit ☐ Other

Treaty Status (if applicable)

Band Name:

10 Digit Treaty Number:

Next of Kin (to be notified in case of emergency): | Relationship to the Applicant:

Phone Number: | Email Address:

Secondary Next of Kin: | Relationship to the Applicant:

Phone Number: | Email Address:

If prescriptions or ambulance services are required, how will they be paid for?
(SIS, AISH, Blue Cross, Health Canada (INAC), etc.?)

Benefits Number:

Cardinal Recovery Homes Application

Legal Matters

****All Legal Matters must be dealt with prior to moving into Cardinal Recovery Homes****

Please check off any conditions that apply and complete the section below. (Please attach any legal orders)

Federal	**Provincial**	
☐ Parole	☐ Probation	☐ Temporary Absence
☐ Statutory Release	☐ Recognizance	☐ Conditional Sentencing

Type of Offence:

Name of Parole/Probation Officer:	Parole/Probation Officer's Agency:	Telephone Number:

If you have a history of criminal convictions, list the type of approximate dates and conviction(s)

Recent charges from the past year. (We may require supporting documentation)

If currently under the care of a Doctor/Psychologist/Psychiatrist, complete the following boxes below:

	Name:	Phone Number:
☐ Doctor ☐ Psychologist ☐ Psychiatrist		

What are your goals while in the Cardinal Recovery Homes?

- ☐ Work
- ☐ School
- ☐ Meetings
- ☐ Other (explain)

Is there anything else you want to share about yourself?

Cardinal Recovery Homes Application

Medical Assessment

This medical assessment is required as part of the application and must be completed in full by a **medical doctor.**

Please note we will not accept medicals without the client's name, date of birth, and health card number.

Patient Name (last, first, initial)	Date of Birth (YYYY-MM-DD)	Personal Health Care Number

Allergies (eg. drug, food, latex, other)	Special Dietary Requirements

Review of Systems (please send relevant reports, eg. CBC, hepatic profile, electrolytes, urinalysis, etc)

EENT

Respiratory (eg. asthma, COPD)	Cardiovascular (eg. CVA, MI, HTN, arrhythmia, pacemaker)
Gastrointestinal (eg. GERD, history GI bleed, hepatitis, pancreatitis)	Genitourinary (eg. incontinence, BPH, STD)
Musculoskeletal (eg. chronic pain, RA, OA, gout)	Integumentary (eg. psoriasis, eczema)

Neurological: Does the patient have a history of seizures?

- ☐ No
- ☐ Yes:

Hematological/Immune (eg. HIV+, HCV+)	Evidence of withdrawal or intoxication? (eg. ETOH, Opioid)

Other (specify)

Physical Examination

Height	Weight	Temperature	Pupils	Heart Rate	Blood Pressure	Respiration Rate

Skin	Diaphoresis	Tremor

Is the patient diabetic?

- ☐ No
- ☐ Yes:

Year Diagnosed

Is the patient stable?

- ☐ No
- ☐ Yes

Does the patient have MRSA and wound?

- ☐ No
- ☐ Yes, specify latest swab results:

Is there cognitive impairment?

- ☐ No
- ☐ Yes:

Cardinal Recovery Homes Application

Needs assistance ambulating or providing self care?

☐ No

☐ Yes:

When was the patient's last PAP smear?

What were the results?

Pregnancy

Is the patient pregnant?

☐ No, complete all boxes →

☐ Yes, complete all boxes →

LMP	Para	Gravida

EDC	Urine HCG	Blood work	Ultrasound	Blood type

Does the patient have current pregnancy complications or had a history of pregnancy complications?

☐ No

☐ Yes, specify:

Physician managing the pregnancy and delivery:

Phone:

Fax:

Address of planned location of delivery:

TB Screening- Symptoms and History

Check the appropriate boxes	No	Yes
Presence of cough lasting more than 2 weeks	☐	☐
Weight loss, if yes specify lbs. in length of time	☐	☐
Night sweats	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Haemoptysis (blood in sputum)	☐	☐
Previous active TB and treatment	☐	☐
Previous significant Mantoux or chest x-ray results	☐	☐
Extensive travel (or birth) in a country with high incidence of TB	☐	☐
Other risk factors (i.e. aboriginal, elderly, homeless, health care worker)	☐	☐
Poor general health status and risk factors for progress of disease	☐	☐
Further TB screening/assessment required- if yes, please send results	☐	☐

Medical Approval

In your opinion, is this patient medically stable and appropriate for the Cardinal Recovery Homes?

☐ No

☐ Yes

Physician's Name	Signature	Date (YYYY-MM-DD)

Psychiatric Review/ History (Please attach any psychiatric evaluations and/or discharge summaries (if available)

Note the **date of last use**, pattern of abuse and severity of addiction

(e.g. alcohol, cocaine, opioids, cannabis, gambling, tobacco, etc.)

Primary: **Secondary:** **Tertiary:**

Cardinal Recovery Homes Application

Is there evidence of the following? (Please include your judgement related to current severity of mental health concerns)	No	Yes	Comments
Mental development and/or learning disorders? (e.g. depression, anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)	☐	☐	
Underlying pervasive or personality conditions	☐	☐	
Acute medical conditions and physical disorders aggravating mental health (e.g. brain injury, cognitive impairment, chronic pain, insomnia)	☐	☐	
Contributing psychosocial and environmental factors	☐	☐	
Global Assessment of Functioning	☐	☐	
Is there a history of self-harm, suicidal thoughts or suicide attempts? (If yes, pertinent psychiatric reports/assessments are required)	☐	☐	

Psychological Approval

In your opinion, is this patient psychologically stable and appropriate for admission to Residential Addiction Treatment?

- ☐ No
- ☐ Yes

Physician's Name	Signature	Date (YYYY-MM-DD)

Medications (if more room is needed, attach list)

At Cardinal Recovery Homes, we have a **restricted medication list that indicates medications we do not allow residents** to have. Please see the following page for further details.

Medication	Dose	Route	Frequency	Reason given	Start Date	End Date	Prescribed By	Phone Number

Please remind the patient that in order to be admitted to Cardinal Recovery Homes, they need to:

- ☐ Be alcohol and drug-free
- ☐ Please discuss any restricted medication at your initial appointment to avoid any delays in processing your application
- ☐ Ensure any new medications not listed above have been pre-approved by the Admissions department
- ☐ If you plan to discontinue any medication(s) we request so in writing by your physician
- ☐ If you receive an alternative medication(s) we request a new prescription list
- ☐ If the patient's medical or psychological condition changes before their position date, they must contact the Admissions department.

Cardinal Recovery Homes Application

Client's Name	Signature	Date (YYYY-MM-DD)

Physician's Name	Signature	Date (YYYY-MM-DD)

Mailing Address:		City/Town:	
Province:		Postal Code:	
Phone:		Fax:	
Primary Physician's Name (if different than above)			
Phone:		Fax:	
Other (e.g.: psychiatrist or other specialist relevant to this admission)			
Phone:		Fax:	

Please ensure the medical portion is signed and stamped by the medical physician who completed the forms. Failure to do so may cause delays in processing your application.	Physician's Stamp

Restricted Medications

Note: this list is not exhaustive and other medications may be subject to restriction

Opioid Pain Medications • Codeine & Codeine containing products (e.g. Tylenol #3) • Morphine (eg. Kadian) • Fentanyl • Hydromorphone (Dilaudid) • Oxycodone (Percocet, OxyNeo) • Meperidine (Demerol) • Tapentadol (Nucynta) • Tramadol (Zytram, Ralivia, Tridural) • Pentazocine (Talwin) • Propoxyphene (Darvon)	**Benzodiazepines** • Alprazolam (Xanax) • Bromazepam (Lectopam) • Lorazepam (Ativan) • Oxazepam (Serax) • Temazepam (Restoril) • Triazolam (Halcion) • Chlordiazepoxide (Librium) • Clonazepam (Rivotril) • Clorazepate (Tranxene) • Diazepam (Valium) • Flurazepam (Dalmane) • Nitrazepam (Mogadon)
Psychostimulants • Dextroamphetamine (Dexedrine) • Amphetamine Mixed Salts (Adderall XR) • Lisdexamfetamine (Vyvanse) • Methylphenidate (Ritalin, Biphentin, Concerta) • Modafinil (Alertec)	**Miscellaneous** • Varenicline (Champix) • Nabilone (Cesamet) • Dronabinol (Marinol) • Medical Marijuana • Zopiclone (Imovane)

Cardinal Recovery Homes Application

Applicant Declaration and Consent

By submitting this application, I confirm that I have read, understood, and agreed to comply with the rules and regulations of Cardinal Recovery Homes upon acceptance.

I acknowledge and consent to the following:

- Drug and Alcohol Policy: Random drug testing may be conducted. Residents suspected of substance use, disruptive behaviour, or nonpayment may be evicted by house vote or PML Staff.
- Personal Belongings: I will remove all personal items within 72 hours of leaving the residence.
- Disclosure: False or misleading information may result in eviction.
- Information Release: I authorize Cardinal Recovery Homes to access and share relevant personal, medical, and treatment information for program purposes.

This consent is confidential and intended solely for operational, therapeutic, and administrative use, in accordance with Saskatchewan's privacy legislation.

Print Name	Signature	MM/DD/YY