

Admission Date _____
 Graduation Date _____
 Confirmation Date _____



AVENTA

CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

610 - 25 Avenue S.W.
 Calgary, Alberta T2S 0L6
 Phone: (403) 245-9050
 Fax: (403) 245-9485

Application for Admission Assessment & Admission Information

YOU MUST CALL TO BOOK YOUR ASSESSMENT AFTER YOU SEND IN THIS APPLICATION

Assessment & Assessment Fee Call 403-245-9050	When you send in your application, please phone Aventa to book an assessment. You will need to pay the \$40 assessment fee before your assessment appointment. We accept Cash, Debit, e-Transfers, VISA, Mastercard, Bank Drafts, and Money Orders. We do not accept personal cheques. If a third party has agreed to pay this fee, Aventa requires confirmation of the information for invoice purposes. Please have the third party contact Aventa with their written agreement prior to your appointment. Aventa Staff can provide support options while Clients wait for treatment.
Confirmation of Treatment Call 403-245-9050	Once you are booked for treatment, you will be given a confirmation date 1 week prior to your admission. Please contact Aventa on this date before 4:00 pm to confirm your date of admission (a phone message is acceptable). If you do not confirm, your bed may be given to another Client.
Treatment Hours at Aventa	Treatment groups run 6 days/week. All Clients are required to attend 12 Step meetings on Sundays at Aventa.
Abstinence Prior to Treatment /To be Determined with Aventa staff dependent on drugs consumed	You must stop gambling and using drugs and alcohol a minimum of 5 days before your admission. You must also pass a drug and alcohol screen, so we recommend you abstain for as long as possible to clear all substances from your system. If you need help to stop using drugs and alcohol or gambling prior to your admission, let us know and we will help you with a referral. It is a good idea to talk to your doctor about your plan to stop using drugs and alcohol, in case you experience withdrawal symptoms.
Abstinence During Treatment	All Clients must refrain from gambling and using drugs and alcohol during treatment, and avoid licensed/gambling facilities. If you use drugs or alcohol or gamble during treatment, you will be discharged immediately. Drug and alcohol screening will be required at the time of admission and anytime during treatment, at the discretion of Staff.
Prescription and Non Prescription (Over the Counter) Medications	All medications, vitamins, and supplements must be approved by your doctor prior to admission by completing the attached Pre-Admission Medical. This must be submitted 2 weeks prior to your admission date. Medications must be in their original packaging with original labels, and match your Pre-Admission Medical.
Team Communication	Open communication occurs between all Aventa Counsellors. Aventa strictly upholds Client confidentiality outside of the agency.
Visitation Hours	Visiting hours are on Saturday afternoons only. Visitors must be approved in advance by your counselor. You will not be able to have visitors on your first weekend in treatment.
Appointments	All appointments must be pre-approved by your Counsellor and are at Aventa's discretion. Please try to take care of all appointments before treatment.
Smoke-Free/Scent Free Centre	Smoking is only allowed outside and at designated times. Counsellors and Medical Staff can provide assistance to Clients who want to quit smoking. Wearing perfumes/ scents is not allowed.
Phone Contact	Phone messages are not accepted by Aventa Staff. Clients have limited access to telephones. Long distance calls require a phone card.
Fees for Treatment	Payment is due prior to admission. No refunds are given. Aventa is a Funded Service of Alberta Health Services (AHS); treatment program fees are covered through AHS. Room and Board fees for clients on income assistance are funded through Alberta Employee Immigration and Industry (AEII). An additional funding partner is Child and Family Services. Please speak with Aventa's Admissions Counsellor as you may qualify under these partnerships. Employee Assistance Programs - If you have coverage through your Employee Assistance Program your fees may be covered through your plan. Please disclose this information during the assessment so we can start the process as soon as possible. Self-Payers - Please speak with our Assessments Department.



Consent for Assessment

I, _____ (Please print name) declare that I am 18 years of age or older and that the Assessment process has been explained to me. I understand that the purpose of this Assessment is to make recommendations for addiction treatment. I have been informed that completing this Assessment does not guarantee that I will receive treatment at Aventa.

Signed

Date

Assessment Fee

I understand that I will be required to pay a \$40 assessment fee prior to my assessment. (This can only be billed to a third party if you bring their written agreement to your assessment).

Signed

Date

Limits of Confidentiality Agreement

I, _____, understand that my treatment and any information I may share at Aventa is confidential and that any release of information shall require a signed release from me.

I further understand the following **limits of confidentiality**. Aventa staff may release pertinent information to the appropriate authorities including, but not limited to, police officers, medical personnel, the Child and Family Service Authority, without a signed release in the following circumstances:

- a. The information involves a threat of harm to self or others.
- b. The information involves concerns about the abuse or neglect of a child.
- c. When Aventa is legally obligated to do so (e.g. a client's file or staff member is subpoenaed by the judicial system).

I understand that treatment information is recorded in my client file for reference and that Aventa staff share information to assist them in delivering the most effective treatment.

Signed

Date

Witness

Date



Medical Release and Collection of Confidential Information

I, _____ give permission to Aventa Addiction Treatment for Women to contact:

TO/FROM	Organizations: CUPS, Mission Clinic, EMS, Urgent Care or other Hospital Medical Staff, the Alex Community Health Bus, Dental Bus Psychiatrist, Physicians, Nurses, Dentists or Pharmacists who you have seen within the last 6 months or while you are in treatment at Aventa
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WHAT INFORMATION	To release verbally or in writing: Please check the following information to be released: <input checked="" type="checkbox"/> Assessment <input type="checkbox"/> Participation <input type="checkbox"/> Attendance <input checked="" type="checkbox"/> Program Dates <input type="checkbox"/> End-Summary & Recommended Actions <input type="checkbox"/> Progress Summary <input checked="" type="checkbox"/> Other (Please Specify) Any relevant medical information	To collect verbally or in writing: Please check the following information to be collected: <input checked="" type="checkbox"/> Assessment <input checked="" type="checkbox"/> Progress Summary <input checked="" type="checkbox"/> Attendance <input checked="" type="checkbox"/> Reason for Referral <input checked="" type="checkbox"/> Relevant History <input checked="" type="checkbox"/> Service Monitoring <input checked="" type="checkbox"/> Participation <input checked="" type="checkbox"/> Treatment Summary <input checked="" type="checkbox"/> Other (Please Specify) Any relevant medical information
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CONSENT	<p>I understand that provision of treatment services is not 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 this cancellation.</p> <p>Client Signature: _____</p> <p>Witness: _____</p> <p>Date signed: ____ / ____ / ____ Day Month Year</p> <p>Permission will expire on: ____ / ____ / ____ Day Month Year</p>
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CANCEL	<p>I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation.</p> <p>Client Signature: _____</p> <p>Witness: _____</p> <p>Date signed: ____ / ____ / ____ Day Month Year</p>
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Application for Treatment

GENERAL INFORMATION

Name _____
Last First Middle

Maiden Name _____ Aliases _____
Last Last First Middle

Address _____
Apartment & Street number City & Province Postal Code Quadrant Home Town

Home Phone () _____ Cell Phone () _____

Other Phone () _____ Email Address _____

Alberta Health Care Number _____ Date of Birth _____

What ethnic group do you identify yourself with? (Please circle) Aboriginal, African, Arab, Caucasian, Chinese, Filipino, First Nations, Inuit, Inuvialuit, Japanese, Korean, Latin, Central or South American, Metis, Mixed Race, South Asian, SE Asian, W Asian
What is your first language (mother tongue)? _____ (i.e. English, French, Cree, Blackfoot, etc.)

REFERRAL SOURCE

Who referred you to Aventa?

- AA Community
- AHS Addiction Mental Health
- Access Mental Health
- Child Welfare
- Community Organization
- Counsellor
- Employer
- Family/Friend
- Hospital
- Legal/Justice
- Physician
- Self
- Other _____

Referral Source Name _____ Referral Source Agency _____

Phone () _____ Fax () _____

What is the reason for applying to treatment at the current time?

Are you required to attend treatment by any of the following?

- Children's Services
- Employer
- Drug Court
- Probation
- Parole
- Court
- Other: _____

FUNDING SOURCE

Current means of financial support _____

Funding source worker's name _____ Office location _____

Phone () _____ Fax () _____

If Applicable: AISH/AEI Benefits Number _____ Treaty Number _____ FPS Number _____

EMPLOYMENT

What is your highest level of education?

- Gr.1-9
- Gr.10-12
- Some Post-Secondary
- University Degree
- College Diploma/Degree

Do you have a profession, trade, or skill? Yes No

Are you currently employed? Yes No



Application for Treatment

HOUSING

Are you currently homeless (i.e. no fixed address, couch-surfing)? Yes No

What is your usual living arrangement?

- with sexual partner & children
- with sexual partner alone
- with children alone
- with parents
- with family
- with friends
- alone
- controlled environment
- no stable arrangement

Do you currently live with anyone who has a current addiction issue? Yes No

ADDICTION INFORMATION

How has your addiction affected these areas of your life?

Family _____

Emotional _____

Social _____

Physical _____

Work/School _____

Spiritual _____

ALCOHOL AND DRUG HISTORY

What is your primary addiction? _____

What is your secondary addiction? _____

Please list all withdrawal symptoms you have experienced in the past year: _____

How long have you been able to abstain from alcohol and/or substances? _____

Please list any substances abused (past and present), including drugs, alcohol, solvents, prescriptions, over the counter medications, etc.

TYPE OF SUBSTANCE	AMOUNT USED	PATTERN OF USE (daily, weekly, route of administration etc.,)	LAST USE DATE	LENGTH OF USE



Application for Treatment

GAMBLING HISTORY

Which types of gambling (past and present) you have participated in:

- Bingo VLT's Slots Internet Casinos Scratch tickets Cards Lotteries

TYPE OF GAMBLING	AMOUNT SPENT	PATTERN OF USE (daily, weekly, etc.)	LAST USE DATE	LENGTH OF USE

Have you spent more money than you intended on any of the above activities? Yes No

Please list any gambling withdrawal symptoms you have experienced in the last year: _____

How long have you been able to abstain from gambling? _____

OTHER HISTORY

Do you identify with any of these behaviors as being problematic?

- Internet Relationships Shopping Sex Food Other _____

If you checked yes on Food, would you describe it as an eating disorder? Yes No

Have you ever tried to abstain from any of the above activities? Yes No

What is the longest you have ever been able to abstain? _____

Has anyone ever expressed concern about your involvement in these activities? Yes No

EATING HISTORY

Have you experienced a time when food controls you or interferes with your life? Yes No

Do you avoid or limit certain types of food (e.g., fat, carbohydrates)? Yes No

How often do you weigh yourself? _____

SMOKING HISTORY

Do you currently smoke cigarettes? Yes No If yes, are you interested in quitting? Yes No

How many cigarettes do you smoke daily? None 5 or less half a pack one pack more than one pack

TREATMENT AND DETOX HISTORY

Is this your first time accessing any form of treatment? Yes No

Have you previously been assessed or received treatment at Aventa? Yes No

Date(s) _____ Did you complete the program? Yes No



Application for Treatment

Please list other addiction treatment or detox programs:

AGENCY	REASON FOR TREATMENT	DATES	COMPLETION	
			YES	NO

FAMILY AND SOCIAL HISTORY

What is your partnership status? Single Married Common Law/Partnered Divorced Widowed Separated

What sexual orientation do you identify yourself with? Straight Gay/Lesbian Bisexual Two Spirited

Is there an addiction history in your family? Yes No

If yes, please specify who and what they used.

Do you parent children under the age of 18? Please list all applicable children.

Name	Age	Sex	At Home?	Child Welfare Involvement
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

With whom do you spend most of your free time? Family Friends Alone

How many close friends or family members do you have? _____

Have you had significant periods in which you have experienced serious problems getting along with:

Family Friends Co-workers _____

Please list all supports you have (i.e. 12 Step, family, friends, church, community agencies, etc.)

TRAUMA/LOSSES HISTORY

Have you experienced any of the following types of abuse/trauma?

Sexual Abuse Financial Abuse Loss of Job/Schooling Domestic Violence Physical Abuse

Emotional Abuse Sex Work Other _____

Have you experienced any of the following types of significant life losses?

Death Health problems Divorce/separation Loss of a job Other _____

Are you experiencing any of the following presenting concerns:

Problems with family Housing problems Problems with social environment

Financial problems Educational problems Problems with access to health care

Occupational problems Legal problems Other concerns: _____



Application for Treatment

LEGAL HISTORY

Do you have any of the following legal issues: Parole Probation Incarcerated (including Remand)

House Arrest Conditional Sentence No Contact Order

Do you have any outstanding legal charges? Yes No Upcoming court date(s) _____

Do you have any other legal issues? Yes No

If yes, please provide details _____

MEDICAL AND HEALTH HISTORY

Are you on methadone? Yes No

Are you currently pregnant? Yes No If yes, please specify due date/or number of months pregnant _____

If yes, have you received pre-natal care? Yes No

Please indicate whether you have any of the following health problems or diseases (now or in the past).

- | | | |
|------------------------------------------|------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Gastrointestinal/Stomach problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Respiratory problems | |

For people with chronic pain problems:

Have you been diagnosed by a medical professional? Yes No If yes, when? _____

Does your pain interfere with your daily activities? Yes No If yes, how? _____

How do you currently manage your pain? _____

Please describe any other health problems you have had that are not listed above:

Please identify any surgeries that have affected your addiction and/or have resulted in substance abuse.

Please describe any accidents or injuries that have been directly or indirectly related to substance abuse.

How many times in your life have you been hospitalized for medical problems? _____

How long ago was your last hospitalization for a physical problem? _____

Do you have a family physician? Yes No

If yes, Physician Name _____ Phone () _____ City: _____

Do you have any issues that require accommodation? (hearing loss, difficulty reading or writing, mobility, etc.)



Application for Treatment

PSYCHOLOGICAL AND MENTAL HEALTH INFORMATION

Are you currently involved with a mental health professional? Yes No

If yes, please specify: (i.e. Psychiatrist, psychologist, therapist) _____

Name _____ Phone () _____ City: _____

Do you have a current formal mental health diagnosis? Yes No When, and by whom? _____

Do you have a past mental health diagnosis? Yes No When, and by whom? _____

If yes, please check all that apply:

- ADD/ADHD Anxiety Disorders Bipolar Depression Dissociative Disorder
- Fetal Alcohol Spectrum Disorder Obsessive Compulsive Disorder Post-Traumatic Stress Disorder
- Schizophrenia Other: _____

Do you have a Guardian or Trustee Order under The Adult Guardianship and Trusteeship Act? Yes No

Do you experience trouble with sleeping:

- Staying asleep Falling asleep Night terrors Snoring Sleepwalking

Have you ever been hospitalized for a mental health reason? Yes No

Please indicate the dates and reason for hospitalization. _____

Have you had any suicidal thoughts or attempts in the past year? Yes No

Do you have any past history of suicidal thoughts or attempts? Yes No

Please indicate the dates and circumstances _____

Have you had any involvement with self-harm in the past year? Yes No

Do you have any past history of self-harm behaviors? Yes No

If yes, please indicate the dates and circumstances _____

I hereby give Aventa staff permission to contact my funding source (AEI, CW) to confirm funding for treatment. I will call Aventa with the name and contact information once I know who that is:

Client printed name: _____ Client signature: _____

Agency: _____, Contact Name: _____, Phone Number: _____

YOU MUST CALL TO BOOK YOUR ASSESSMENT AFTER YOU SEND IN THIS APPLICATION

Items to Bring to Treatment

Please bring Aventa's **Medication Form** completed by your doctor indicating all approved prescription medications, over-the-counter medication, herbal supplements and vitamins. There is not a lot of storage space so you are only allowed 1 medium and 1 small sized suitcase, ***everything you bring must fit in these 2 suitcases.*** If you bring anything extra you will just be asked to have them sent away before you are admitted onto the floor.

PLEASE BRING A THREE WEEK SUPPLY AS THERE IS NO SHOPPING DURING TREATMENT

Clothing:

*****Nothing that includes drug / alcohol / gambling logos or paraphernalia**

- 5 Pairs of pants (including one pair for recreation/ yoga)
- 9 T-shirts/ tops
- 2 Sweatshirts or sweaters
- 10 Pairs of underwear and socks
- 2 Sets of pajamas & 1 Bathrobe
- 1 Small purse with only one or two pouches / pockets on it

**** All footwear must have a non-cloth sole and a back over the heel**

- 1 Pair of runners
- 1 Pair of walking shoes
- 1 Set of outdoor wear (seasonal)

Miscellaneous:

- Spending money (for payphone, etc.)
- \$5.00 deposit for key to closet in room
- Bus tickets (for meetings, recreational activities)
- Writing paper, binder, pens/pencils, notebook
- Phone cards
- Cigarettes
- Water bottle with a lid

Personal Care Products:

*****All personal care products must be scent and alcohol free. Approved items include pump hairsprays, mousse products with Denatured Alcohol and cream-based shampoos, conditioner and body lotion.**

Brush and/or comb, shampoo and conditioner

- Hair products (gel or mousse)
- Laundry soap (HE powder or liquid)/Fabric Softener (liquid only)
- Deodorant
- Body cream/lotion
- Soap or body wash
- Toothpaste, tooth brush, & floss
- Feminine care products (pads/tampons)
- Pencil size case (only) of make-up
- Nail clippers, nail file

Optional:

- Spiritual necessities (Bible, smudging materials)
- Blow dryer or curling iron (**no straightening irons**)
- Alarm Clock
- 5 CDs
- 3 books of any kind
- Craft supplies – No paint
- A few pictures not in frames

LEAVE AT HOME (Not Permitted under any Circumstance):

- | | | |
|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------|
| • Any gambling items including playing cards, all forms of lottery tickets, scratch tickets, 50/50 tickets or Nevadas | • Medications/supplements not approved in writing by your doctor | • Ghetto blasters, gaming devices or any other electronics |
| • Flip flops or shoes that do not have a heel strap/cloth sole | • Pillows or any linen supplies | • Cell phones |
| • Tanning products | • Stuffed toys | • Laptops, iPads, tablets |
| • Teeth Whitening products | • Food | • DVDs |
| • Hair dye of any kind | • Sexual toys/aids | • Ashes of loved one or pets |
| • Perfumes and body sprays | • No paint of any kind | • Cigars, loose tobacco or e-cigarettes of any kind |
| • Large sums of money (over \$60) | • Fabric softener sheets | |
| • Nail care products (polish/remover) | | |

I have read the above list and agree to only bring the approved items. If I arrive to Aventa with items that are not allowed or have additional items I understand that I may not be admitted to the program.

Client Signature: _____

Date: _____



Attention Referring Physicians

Aventa is a residential addiction treatment facility for women. Clients attend for a minimum of 6 weeks of treatment. We require that the medical form attached be completed prior to treatment **preferably by the Client's primary care physician.**

Please complete the form with as much detail as possible including **all prescribed and over the counter medications** that you are recommending your client take while in treatment.

Medical checklist:

- All medications must be listed and approved by the physician prior to treatment. If there are any changes prior to coming into treatment a new form must be completed or an amendment made to the initial form and signed by the original MD.
- We require clients to be stabilized on their medications when they begin treatment. We request that any necessary adjustments are made 2-4 weeks prior to treatment.
- Please review the restricted medications list (attached).
- All medications must be in their original packaging. Medications should not be blister-packed.

Feel free to contact us at 403-245-9050 with any questions or concerns.

Thank you for your time and support.

Sincerely,

Aventa Assessments & Admissions

Confidential Pre-Admission Medical Assessment

Applicant's Name: _____ **Date of Birth:** _____

Alberta Health Care Number: _____ **How long have you known this Client:** _____

Last date client had any blood work or other diagnostic testing completed: _____

Have you included any Net Care information on this Client: _____

The following details are to be completed by a medical professional, not by a Client:

MEDICAL HISTORY

	Yes	No	Details	Treatment Plan
GI Concerns				
Diabetes				
HIV/Hepatitis				
STI: Last tested?				
Pain: acute/ chronic				
Dental problems				
Migraine problems				
Eating disorders				
Sleeping disorders				
Respiratory problems				
Seizures				
Allergies				
Pregnancy? Due date?				
Other : please specify				

TB Screening

Does your Client have symptoms? Yes No

Could your Client be infected with active TB? Yes No

If Yes, further investigation may be required before admission to Aventa can be approved.

Has your Client been tested? Yes No If Yes, when _____

Does your Client have any psychological /psychiatric conditions that might interfere with her participation in this program or that need to be taken into consideration? Yes No **If Yes, please explain:**

Does your Client have any physical disabilities that may interfere with activities of daily living (ie. mobility, hygiene, light chores)? Yes No **If Yes, please explain:**

Aventa is a non-medical residential facility; Clients live in shared accommodations. Do you assess this Client suitable for the environment? Yes No **If No, please explain:**

Current Medications

In order for Aventa to allow a Client to bring a medication, (including prescription, non-prescription medications, and supplements) on-site we require:

1. a legible physician’s order including dose, route, timing, and reason for the medication **(print-outs are not accepted)**
2. physician stamp and signature

Medication	Dosages and Times	Duration and Reason

Please list any Restricted Medication the Client has recently taken (See attached list)

Medication	Last Date of Use	Taper Plan

Client’s Consent to Release of Information. I, _____ hereby consent to the release of my medical information to Aventa Addiction Treatment Centre for Women. I also agree to bring only those medications listed above to Aventa on my admission day.

Client Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Physician’s Stamp

Physician’s Telephone Number: () _____

Physician’s Fax Number: () _____

RESTRICTED MEDICATIONS

Information for Clients and Their Doctors

Clients are not permitted to take the following medications while in treatment at Aventa. If a client is taking a restricted medication, please include their tapering plan and your estimated last date of use. The last date of use will help determine when they will clear for drug screening and admission into treatment.

Note: Antidepressants are acceptable

- Benzodiazepines e.g. Valium, Ativan, Rivotril, Serax, etc.
- Sedatives or Sleeping medications e.g. Chloral Hydrate, Ethchlorvynol, Glutethimide, Methypylone, Imovane.
- Barbiturates e.g. Phenobarbital, Seconal.
- Barbiturate-like medications e.g. Meprobamate
- Amphetamines e.g. Ritalin, Dexedrine, Benzedrine
- Diet pills
- Antihistamines
- Decongestants
- Anti-cough medications
- Gravol
- Narcotics e.g. pain killers with codeine, such as Tylenol #1, 2 & 3
- Muscle relaxants
- Laxatives, stool softeners, and other bowel care products.
- Medications containing alcohol
- Mouthwash containing alcohol

***Analgesics (Tylenol/Aspirin)** except for extenuating circumstances (severe arthritis, etc.) to be discussed with Aventa Medical Staff.

Please contact Aventa if you have questions, or if there is a change to your medications in the 10 days prior to starting treatment.