

|                         |
|-------------------------|
| Admission Date _____    |
| Graduation Date _____   |
| Confirmation Date _____ |



AVENTA

CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

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

## Application for Admission

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

Failure to comply with the following rules and regulations may result in admission being delayed or cancelled

| Assessment & Admission Information  |  |
|---|--|
| <p><b>Assessment &amp; Assessment Fee</b><br/>Call 403-245-9050</p>   | <p><b>When you send in your application, please phone Aventa to book an assessment.</b> 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. <b>We do not accept personal cheques.</b> 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.</p> |
| <p><b>Confirmation of Treatment</b><br/>Call 403-245-9050</p>   | <p>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). <b>If you do not confirm, your bed may be given to another Client.</b></p>  |
| <p><b>Treatment Hours</b></p>   | <p>Treatment groups run 6 days/week. All Clients are required to attend 12 Step meetings on Sundays.</p>   |
| <p><b>Abstinence Prior to Treatment /To be Determined with Aventa staff dependent on drugs consumed</b></p> | <p>You must stop gambling and using alcohol and drugs, including restricted medications, for a <b>minimum of 10 days</b> before your admission. You must also pass a drug and alcohol screen, so we recommend you abstain for as long as necessary 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.</p>                               |
| <p><b>Abstinence During Treatment</b></p>   | <p><b>All Clients must refrain from gambling and using drugs and alcohol during treatment, and avoid licensed/gambling facilities. If you use drugs, including restricted medications, alcohol or gamble during treatment, you will be discharged immediately.</b> Drug and alcohol screening will be required at the time of admission and anytime during treatment, at the discretion of Staff.</p>  |
| <p><b>Prescription and Non Prescription (Over the Counter) Medications</b></p>                              | <p>All medications, vitamins, and supplements must be approved by your doctor prior to admission by completing the attached Pre-Admission Medical, and submitted 2 weeks prior to your admission date. Medications must be in their original packaging with original labels, and match your Pre-Admission Medical.</p>   |
| <p><b>Team Communication</b></p>  | <p>Open communication occurs between all Aventa Counsellors, clinical practicum students and supervisors. Aventa strictly upholds Client confidentiality outside of the agency.</p>  |

|                                     |  |
|-------------------------------------|--|
| <b>Visitation Hours</b>             | Visiting hours are on Saturday and visitors must be approved in advance by your Counsellor. You will not be able to have visitors on your first weekend in treatment.  |
| <b>Appointments</b>                 | 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.   |
| <b>Smoke-Free/Scent Free Centre</b> | Smoking is only allowed outside and at designated times only. Counsellors and Medical Staff can provide assistance to Clients who want to quit smoking. Wearing perfumes/ scents is not allowed.   |
| <b>Phone Contact</b>                | Phone messages are not accepted. Clients have limited access to telephones. Long distance calls require a phone card. <b>Cell phones are not permitted. Please do NOT bring them to treatment.</b>   |
| <b>Fees for Treatment</b>           | <p><b>Payment is due prior to admission.</b> Aventa is a Funded Service of Alberta Health Services (AHS); treatment program fees are covered through Alberta Health Services, but AHS does not provide funding for room and board fees. Room and board fees for Clients on income assistance is funded through Alberta Works. If you are not covered by Alberta Works, AISH, or your Employee Assistance Program (EAP), you will be required to pay the room and board fee at a rate of \$50.00 per day. Refunds are provided under exceptional circumstances as approved by the Executive Director.</p> <p>Additional funding partners include Child and Family Services and Calgary Fetal Alcohol Network. Young Adult Treatments program assessments are managed accessed through Alberta Health Services Addiction and Mental Health contact your local AHS Addictions Services office. Please speak with Aventa's Admissions Counsellor as you may qualify under these funding opportunities. Please note that when you apply for programs and services at Aventa, your name and demographic information will be shared with the applicable Alberta Government funding partner for statistical purposes.</p> <p><b>Employee Assistance Programs</b> - 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.</p> <p><b>Self-Payers</b> – Please speak with our Assessments Department.</p> |
| <b>Transportation</b>               | Clients are responsible for arranging and paying for their transportation costs for admission to Aventa as well as throughout treatment. <b>Please do not bring your vehicle</b> as parking is not available.  |
| <b>Electronics</b>                  | No electronic devices (i.e. iPads, cell phones, laptops, etc.) are permitted in the building. Clients will have access to laptop computers once each week for business purposes.   |



## 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 among relevant Aventa Staff which may include the clinical team, management, practicum students and external supervisors of Registered Provisional Psychologists, to assist them in delivering the most effective treatment.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



### Pre-Admission Medical Release and Collection of Confidential Information (For the purpose of Admission into Aventa's Programs)

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

|                |  |
|----------------|--|
| <b>TO/FROM</b> | <b>Organizations: CUPS, Mission Clinic, EMS, Urgent Care or other Hospital Medical Staff, the Alex Community Health Bus, Dental Bus</b><br><b>Psychiatrist, Physicians, Nurses, Dentists or Pharmacists who you have seen within the last 6 months or while you are in treatment at Aventa</b> |
|----------------|--|

|                         |  |  |
|-------------------------|--|--|
| <b>WHAT INFORMATION</b> | <b>To release verbally or in writing:</b><br>Please check the following information to be released:<br><input checked="" type="checkbox"/> Assessment <input type="checkbox"/> Participation<br><input type="checkbox"/> Attendance <input checked="" type="checkbox"/> Program Dates<br><input type="checkbox"/> End-Summary & <input type="checkbox"/> Progress Summary<br>Recommended <input type="checkbox"/> Treatment Plan<br>Actions<br><input checked="" type="checkbox"/> Other (Please Specify)<br><b>Any relevant medical information</b> | <b>To collect verbally or in writing:</b><br>Please check the following information to be collected:<br><input checked="" type="checkbox"/> Assessment <input checked="" type="checkbox"/> Progress Summary<br><input checked="" type="checkbox"/> Attendance <input checked="" type="checkbox"/> Reason for Referral<br><input checked="" type="checkbox"/> Relevant History <input checked="" type="checkbox"/> Service Monitoring<br><input checked="" type="checkbox"/> Participation <input checked="" type="checkbox"/> Treatment Summary<br><input checked="" type="checkbox"/> Other (Please Specify)<br><b>Any relevant medical information</b> |
|-------------------------|--|--|

|                |   |
|----------------|---|
| <b>CONSENT</b> | <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><b>Client Signature:</b> _____</p> <p><b>Witness:</b> _____</p> <p><b>Date signed:</b> ____ / ____ / ____<br/>                                           <b>Day                      Month                      Year</b></p> <p><b>Permission will expire on:</b> ____ / ____ / ____<br/>                                           <b>Day                      Month                      Year</b></p> |
|----------------|---|

|               |  |
|---------------|--|
| <b>CANCEL</b> | <p>I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation.</p> <p><b>Client Signature:</b> _____</p> <p><b>Witness:</b> _____</p> <p><b>Date signed:</b> ____ / ____ / ____<br/>                                           <b>Day                      Month                      Year</b></p> |
|---------------|--|



Application for Treatment

**GENERAL INFORMATION**

Name \_\_\_\_\_  
Last First Middle

Maiden Name \_\_\_\_\_ Aliases \_\_\_\_\_  
Last Last First Middle

Address \_\_\_\_\_  
Apartment & Street number City & Province Postal Code Home Town

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Other Phone ( ) \_\_\_\_\_ Email Address \_\_\_\_\_

Alberta Health Care Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ (YYYY-MM-DD)

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

Do you have a Community Treatment Order?  Yes  No

**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<br>(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<br>(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).

- Arthritis
- Blood disorders
- Brain Injury
- Cancer
- Chest Pains
- Chronic Pain
- Dental
- Diabetes
- Dizziness
- Fibromyalgia
- Food Allergies
- Gastrointestinal/Stomach problems
- Heart Problems
- Hepatitis
- HIV/AIDS
- Hormone problems
- Liver problems
- Migraines
- Osteoporosis
- Respiratory problems
- Seizures
- Skin problems
- Sleep problems
- Stroke
- Thyroid problems
- Tuberculosis
- Ulcers
- Vision problems
- Other \_\_\_\_\_

**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

Details: \_\_\_\_\_

Guardian/Trustee's Name and Phone Number: \_\_\_\_\_

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 SIX 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 1 or 2 pouches/pockets
- \*\* 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
- Money for bus tickets (for meetings, recreational activities) & emergency taxi fare (medical issues)
- Phone cards
- Cigarettes

### Optional:

- Alarm Clock
- Blow dryer or curling iron (no straightening irons)
- Spiritual items (Bible, smudging materials)

### Personal Care Products:

**\*\*\*All personal care products must be low scent and non-aerosol. Hairspray, mouthwash and hand sanitizer must be alcohol free**

- 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
- Water bottle with a lid
- 3 books of any kind
- Craft supplies – No paint
- A few pictures not in frames
- Writing paper, binder, pens/pencils, notebook

### 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
- Flip flops or shoes that do not have a heel strap/cloth sole
- Tanning products
- Teeth Whitening products
- Hair dye, perfumes/body sprays
- Large sums of money (over \$60)
- Nail care products (polish/remover)
- Musical instruments
- Cars/Motorcycles
- Medications/supplements not approved in writing by your doctor
- Pillows or any linen supplies
- Stuffed toys
- Food
- Sexual toys/aids
- Paint
- Fabric softener sheets
- Ghetto blasters, gaming devices or any other electronics
- **Cell phones**
- Laptops, iPads, tablets, DVDs
- Ashes of loved ones or pets
- Pets
- Cigars, loose tobacco or e-cigarettes

**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 with the exception of Seroquel.

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



AVENTA

CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

### 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?<br>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:**

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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:**

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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:**

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**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 restricted medication, please include their tapering plan and your estimated last date of use. **Clients are required to be stable on their medications** with no medication changes (reduction, increases or additions) for a minimum of 2 weeks before admission to ensure medical stability. The last date of use will help determine when they will be clear for drug screening and admission into treatment.

- Benzodiazepines e.g. Valium, Ativan (Lorazepam), Rivotril (Clonazepam), Serax, etc.
- Sedatives or Sleeping medications e.g. Chloral Hydrate, Ethchlorvynol, Glutethimide, Methypylone, Imovane (Zopiclone)
- Barbiturates e.g. Phenobarbital, Seconal - Barbiturate-like medications e.g. Meprobamate
- Amphetamines e.g. Ritalin, Dexedrine, Benzedrine, Vyvanse, Concerta
- Diet pills e.g. Ephedrine
- Antihistamines e.g. Diphenhydramine (Benadryl)
- Decongestants e.g. Pseudoephedrine
- Anti-cough medications e.g. Dextromethorphan
- Gravol (Dimenhydrinate)
- Narcotics e.g. pain killers with codeine, such as Tylenol #1, 2 & 3
- Muscle relaxants e.g. Cyclobenzoprine, Flexeril, Robaxacet
- Laxatives, stool softeners, and other bowel care products.
- Medications containing alcohol
- Mouthwash containing alcohol
- THC (Marijuana) Nabilone (Synthetic Marijuana)
- Opiates (Morphine, Oxycodone, Percocet, Fentanyl, etc.)

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

**Although Aventa does allow Methadone and Suboxone for treatment purposes, we do not have carries at Aventa.** All dispensing is through Shoppers Drug Mart at 2412, 4<sup>th</sup> Street Sw.

Please contact Aventa if you have questions.



## COMMUNITY RESOURCES

While you are waiting for your treatment date at Aventa the following resources may be helpful.

**211 Alberta.** You can dial 2-1-1 to speak to an Information & Referral Specialist, or search our online community resource directory <http://www.ab.211.ca/>

**Addiction Helpline** [1-866-332-2322](tel:1-866-332-2322) The Addiction Helpline is a toll free confidential service which provides alcohol, tobacco, other drugs and problem gambling support, information and referral to services. The Addiction Helpline operates 24 hour a day, seven days a week and is available to all Albertans.

**Health Link** Call Health Link by dialing 811 for quick and easy advice from a registered nurse 24/7. They will ask questions, assess symptoms and determine the best care for you.

## OVERDOSE - Reduce Your Risk

Fentanyl may be 100 times more toxic than morphine, heroin, or oxycodone. Even small amounts can result in overdose and it can be found in other drugs without you knowing.

If you're going to use:

- don't use fentanyl, or any other drug, while alone;
- start using in small amounts;
- do 'test shots' (or test doses);
- don't mix drugs;
- avoid speedballing;
- always carry a Naloxone Kit;
- call 911 if you or someone suspects a person is experiencing an overdose. Calling for help can save a life!

IF YOU USE,  
KNOW HOW  
TO USE  
NALOXONE

**NALOXONE:**  
**GET IT. CARRY IT. USE IT.**

[www.stopods.ca](http://www.stopods.ca)

