### 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.

<table>
<thead>
<tr>
<th>Assessment &amp; Admission Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment &amp; Assessment Fee</strong></td>
</tr>
<tr>
<td>Call 403-245-9050</td>
</tr>
<tr>
<td><strong>When you send in your application, please phone Aventa to book an assessment.</strong> 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. <strong>We do not accept personal cheques.</strong> 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.</td>
</tr>
<tr>
<td><strong>Confirmation of Treatment</strong></td>
</tr>
<tr>
<td>Call 403-245-9050</td>
</tr>
<tr>
<td>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). <strong>If you do not confirm, your bed may be given to another Client.</strong></td>
</tr>
<tr>
<td><strong>Treatment Hours</strong></td>
</tr>
<tr>
<td>Treatment groups run 6 days/week. All Clients are required to attend 12 Step meetings on Sundays.</td>
</tr>
<tr>
<td><strong>Abstinence Prior to Treatment /To be Determined with Aventa staff dependent on drugs consumed</strong></td>
</tr>
<tr>
<td>You must stop gambling and using alcohol and drugs, including restricted medications, for a minimum of 10 days 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.</td>
</tr>
<tr>
<td><strong>Abstinence During Treatment</strong></td>
</tr>
<tr>
<td>All Clients must refrain from gambling and using drugs and alcohol during treatment, and avoid licensed/gambling facilities. <strong>If you use drugs, including restricted medications, alcohol or gamble during treatment, you will be discharged immediately.</strong> Drug and alcohol screening will be required at the time of admission and anytime during treatment, at the discretion of Staff.</td>
</tr>
<tr>
<td><strong>Prescription and Non Prescription (Over the Counter) Medications</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Team Communication</strong></td>
</tr>
<tr>
<td>Open communication occurs between all Aventa Counsellors, clinical practicum students and supervisors. Aventa strictly upholds Client confidentiality outside of the agency.</td>
</tr>
<tr>
<td><strong>Visitation Hours</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Appointments</strong></td>
</tr>
<tr>
<td><strong>Smoke-Free/Scent Free Centre</strong></td>
</tr>
<tr>
<td><strong>Phone Contact</strong></td>
</tr>
<tr>
<td><strong>Fees for Treatment</strong></td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
</tr>
<tr>
<td><strong>Electronics</strong></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>TO/FROM</th>
<th>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</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WHAT INFORMATION</th>
<th>To release verbally or in writing:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please check the following information to be released:</td>
</tr>
<tr>
<td></td>
<td>☑ Assessment ☑ Program Dates</td>
</tr>
<tr>
<td></td>
<td>☑ Participation ☑ Progress Summary</td>
</tr>
<tr>
<td></td>
<td>☑ End-Summary &amp; Recommended Treatment Plan</td>
</tr>
<tr>
<td></td>
<td>☑ Any relevant medical information</td>
</tr>
<tr>
<td></td>
<td>☑ Other (Please Specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHAT INFORMATION</th>
<th>To collect verbally or in writing:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please check the following information to be collected:</td>
</tr>
<tr>
<td></td>
<td>☑ Assessment ☑ Progress Summary</td>
</tr>
<tr>
<td></td>
<td>☑ Attendance ☑ Reason for Referral</td>
</tr>
<tr>
<td></td>
<td>☑ End-Summary &amp; Recommended Treatment Plan</td>
</tr>
<tr>
<td></td>
<td>☑ Other (Please Specify)</td>
</tr>
<tr>
<td></td>
<td>☑ Any relevant medical information</td>
</tr>
</tbody>
</table>

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.

Client Signature: ______________________________  
Witness: ____________________________________________

Date signed: ______ / _______ / ______  
Day      Month           Year

Permission will expire on: ______ / _______ / ______  
Day      Month           Year

I, ____________________________________________, cancel this permission. I understand that some action may have been taken prior to this cancellation.

Client Signature: ______________________________  
Witness: ____________________________________________

Date signed: ______ / _______ / ______  
Day      Month           Year
JOURNEYS PROGRAM

Aventa and McMan have collaborated in a joint partnership called the “Journeys” Program, which is designed to deliver timely supports to pregnant or parenting women with addiction issues, in the Calgary area. The program will provide services aimed at reducing risk factors and facilitating successful transitions through recovery by offering pre and post treatment supports. Please note that choosing to, or declining to, participate does not affect your application to Aventa.

Do you currently live in Calgary or surrounding area AND are pregnant or parenting?  ☐ Yes ☐ No

If you answered NO to this question, please skip this form and proceed to the next page 7.

Release and Collection of Confidential Information

I understand that Aventa Center of Excellence for Women with Addictions (Aventa) and McMan Youth, Family and Community Services Association (McMan) are working together to coordinate my treatment and for case management purposes.

I, ____________________________ give permission to Aventa and McMan to release and collect information between the two agencies.

<table>
<thead>
<tr>
<th>WHAT INFORMATION</th>
<th>To release verbally or in writing:</th>
<th>To collect verbally or in writing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Assessment</td>
<td>☒ Program Dates</td>
<td>☒ Assessment</td>
</tr>
<tr>
<td>☒ Attendance</td>
<td>☒ Progress Summary</td>
<td>☒ Attendance</td>
</tr>
<tr>
<td>☒ Treatment Plan</td>
<td>☒ Participation</td>
<td>☒ Relevant History</td>
</tr>
<tr>
<td>☒ End-Summary &amp; Recommended Actions</td>
<td>☒ Other (Please Specify): referrals and supporting documents</td>
<td>☒ Participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☒ Reason for Referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☒ Service Monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☒ Treatment Summary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☒ Other (Please Specify): Health &amp; safety concerns</td>
</tr>
</tbody>
</table>

CONSENT

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 cancellation.

Client Signature: ____________________________________________________________

Witness: ____________________________________________________________

Date signed: ______ / ______ / ______

MM DD YY

Permission to expire on: ______ / ______ / ______

MM DD YY

CANCEL

I, ____________________________, cancel this permission. I understand that some action may have been taken prior to this cancellation.

Client Signature: ____________________________________________________________

Witness: ____________________________________________________________

Date signed: ______ / ______ / ______

MM DD YY
APPLICATION FOR TREATMENT

CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

GENERAL INFORMATION

Name_________________________________________________________________________________________________________________________

Maiden Name__________________________________ Aliases________________________________________________________________________________

Address____________________________________________________________________________________________________________________

Apartment & Street number City & Province Postal Code

Home Phone (          ) ___________________________ Cell Phone (          ) ___________________________

Other Phone (          ) ___________________________ Email Address________________________________________________

Alberta Health Care Number___________________________________ Date of Birth ____________________________ (YYYY-MM-DD)

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

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 ☐ Children’s Services ☐ Community Organization

☐ Counsellor ☐ Employer ☐ Family/Friend ☐ Hospital ☐ Legal/Justice ☐ Physician ☐ Self ☐ Other _____________

Referral Source Name________________________________________ Referral Source Agency_____________________________________

Phone (          ) ___________________________ Fax (          ) ___________________________

If Applicable: AISH/AEI Benefits Number_____________________ Treaty Number ___________________ FPS Number ___________

What is the reason for applying to treatment?

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

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

☐ Children’s Services ☐ Employer ☐ Drug Court ☐ Probation ☐ Parole ☐ Other:____________________

Do you have a Community Treatment Order? ☐ Yes ☐ No

FUNDING SOURCE

Current means of financial support _______________________________ File/Ref # _______________________________

Funding source worker’s name __________________________________ Office location____________________________

Phone (          ) ___________________________ Fax (          ) ___________________________

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
ADDICTION INFORMATION
How has your addiction affected these areas of your life?

Family_______________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

Emotional____________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

Social_______________________________________________________________________________________________________________________

______________________________________________________________________________________________________

Physical_____________________________________________________________________________________________________________________

_____________________________________________________________________

Work/School__________________________________________________________________________________________________________________

_________________________________________________________________________________

Spiritual______________________________________________________________________________________________________________________

______________________________________________________________________________

Is there an addiction history in your family?  □ Yes □ No
If yes, please specify who and what they used.

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

<table>
<thead>
<tr>
<th>TYPE OF SUBSTANCE</th>
<th>AMOUNT USED</th>
<th>PATTERN OF USE (daily, weekly, route of administration etc.)</th>
<th>LAST USE DATE</th>
<th>LENGTH OF USE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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? __________________________________________________________
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

<table>
<thead>
<tr>
<th>TYPE OF GAMBLING</th>
<th>AMOUNT SPENT</th>
<th>PATTERN OF USE (daily, weekly, etc.)</th>
<th>LAST USE DATE</th>
<th>LENGTH OF USE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ____________________________

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

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

Please list other addiction treatment or detox programs:

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>REASON FOR TREATMENT</th>
<th>DATES</th>
<th>COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 □ LGBTQ2S+ □ Unsure □ Prefer not to say

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>At Home?</th>
<th>Children’s Services Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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:________________________

LEGAL HISTORY

Do you have any of the following legal issues:

□ Parole □ Probation □ Incarcerated (including Remand) □ House Arrest □ Conditional Sentence □ No Contact Order

If yes, please provide details ________________________________________________________________

Do you have any outstanding legal concerns (i.e. court dates, charges, trial or sentencing) □ Yes □ No

If yes, please provide details ________________________________________________________________

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: ________________________________________________
MEDICAL AND HEALTH HISTORY

Are you on Methadone?  □ Yes  □ No
Are you on Suboxone?  □ Yes  □ No
Are you on Naltrexone?  □ 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
Do you have a family physician?  □ Yes  □ No
If yes, Physician Name ____________________________ Phone ( ) ________________ City: __________________

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

Please describe any health problems you have that may impact your participation in this program:
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________

Chronic Pain:

Have you been diagnosed with chronic pain 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? ____________________________

_____________________________________________________________________________________________________________________________

Do you experience trouble sleeping:  □ Staying asleep  □ Falling asleep  □ Night terrors  □ Snoring  □ Sleepwalking

Have you been diagnosed with a sleep disorder?  □ Yes  □ No
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 past or current FORMAL mental health diagnosis?  □ Yes □ No
If yes, when and by whom?  ____________________ ____________________________

If yes, please check all that apply:
□ ADD/ADHD □ Anxiety Disorders □ Bipolar □ Borderline Personality Disorder □ Depression
□ Dissociative Disorder □ Eating Disorder □ Obsessive Compulsive Disorder □ Post-Traumatic Stress Disorder
□ Schizophrenia □ Other:__________________________

Do you have a mental health concern WITHOUT a formal diagnosis?  □ Yes □ No
If yes, please check all that apply:
□ ADD/ADHD □ Anxiety Disorders □ Bipolar □ Borderline Personality Disorder □ Depression
□ Dissociative Disorder □ Eating Disorder □ Obsessive Compulsive Disorder □ Post-Traumatic Stress Disorder
□ Schizophrenia □ Other:__________________________

Fetal Alcohol Spectrum Disorder (FASD) is a medical diagnosis that describes the range of brain injuries, birth defects and developmental disabilities that can result when a woman drinks alcohol during pregnancy.

Have you been diagnosed with Fetal Alcohol Spectrum Disorder  □ Yes □ No
Do you suspect you may have Fetal Alcohol Spectrum Disorder  □ Yes □ No
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
If yes, 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
- 1 Pair of runners
- 1 Pair of walking shoes
- 1 Set of outdoor wear (seasonal)

PERSONAL CARE PRODUCTS:

***All personal care products must be low scent and non-aerosol (aerosol mousse is permitted). Hairspray, mouthwash, hand sanitizer, makeup and accessories must be alcohol free. Please limit the amount of these items.

- Brush and/or comb, shampoo and conditioner
- Hair products (gel or mousse – including aerosol)
- Laundry soap (HE powder or liquid)/Fabric Softener (no dryer sheets)
- Body cream/lotion, Deodorant,
- Soap or body wash
- Toothpaste, tooth brush, & floss
- Feminine care products (pads/tampons)
- Pencil case size only of make-up
- Nail clippers, nail file

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

Optional:

- Alarm Clock       - Blow dryer, curling iron, straightening iron       - Spiritual items (Bible, smudging materials)
- Water bottle with a lid
- Craft supplies – No paint / glitter
- Writing paper, binder, pens/pencils, notebook
- Cigarettes

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 Chips or Nevadas
- Large sums of money (over $60)
- Cars/Motorcycles
- Musical instruments
- Tanning products
- Teeth Whitening products
- Hair dye, perfumes/body sprays
- Nail care products (polish/remover/glue)
- Medications/supplements not approved in writing by your doctor
- Laptops, iPads, tablets, DVDs, gaming devices or other electronics
- Cell phones
- Pillows or any linen supplies
- Stuffed toys
- Food
- Fabric softener/dryer sheets
- Sexual toys/aids
- Paint / Glitter
- Ashes of loved ones or pets
- Pets
- Cigars, loose tobacco, e-cigarettes / vapes

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: __________________________

13 Last Updated March 2019
Attention Referring Physicians

Aventa is a residential addiction treatment facility for women. Clients attend a minimum of 6 weeks of treatment. We require that the attached medical form 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

Physician’s Stamp/Initial
Confidential Pre-Admission Medical Assessment

Client’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: _________________________
Please include any Net Care information on this Client: ________________________________

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

<table>
<thead>
<tr>
<th>MEDICAL HISTORY</th>
<th>Yes</th>
<th>No</th>
<th>Details</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI Concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/Hepatitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI: Last tested?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain: acute/ chronic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy? Due date?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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?  □ Yes  □ No

If YES, do you feel these might interfere with her participation in this program or that need to be taken into consideration?

______________________________________________

______________________________________________

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosages and Times</th>
<th>Duration and Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Last Date of Use</th>
<th>Taper Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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/Initial

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 the Client is on 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, Methyprylone, 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. Cyclobenzaprine, Flexeril, Robaxicet
- 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 allow Methadone carries on-site at Aventa;** all dispensing is done through Shoppers Drug Mart at 2412 – 4 Street SW, Calgary, Alberta.

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

**Physician’s Stamp/Initial**
COMMUNITY RESOURCES

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

**Aventa’s Family and Friends**
Family and Friends is a three part information series for all family members, significant others and supportive friends of current and previous Clients, as well as those who did not graduate or are on the waitlist to attend treatment. Workshops run twice per month on Wednesday evenings, as well as one Saturday workshop 4 times per year. All participants must register with Aventa’s Family Counsellor by calling (403) 245-9050.

**211 Alberta.** You can dial 2-1-1 to speak to an Information & Referral Specialist, or search the online community resource directory [http://www.ab.211.ca/](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 24/7 and is available to all Albertans.

**Health Link** Call Health Link by dialing 8-1-1 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 9-1-1 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](image-url)