

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

**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

<b>Assessment &amp; Admission Information</b>	
<b>Assessment &amp; Assessment Fee Call 403-245-9050</b>	<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.
<b>Confirmation of Treatment Call 403-245-9050</b>	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>
<b>Treatment Hours</b>	Treatment groups run 6 days/week. All Clients are required to attend 12 Step meetings on Sundays.
<b>Abstinence Prior to Treatment /To be Determined with Aventa staff dependent on drugs consumed</b>	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.
<b>Abstinence During Treatment</b>	<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.
<b>Prescription and Non Prescription (Over the Counter) Medications</b>	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.
<b>Team Communication</b>	Open communication occurs between all Aventa Counsellors, clinical practicum students and supervisors. Aventa strictly upholds Client confidentiality outside of the agency.

<b>Visitation Hours</b>	Visiting hours are on Saturdays 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-Pay</b> - Please speak with our Assessments Department.</p>
<b>Transportation</b>	Clients are responsible for arranging and paying for their transportation costs in order to attend 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, tablets, cell phones, laptops, gaming devices, 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> <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>
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<b>WHAT INFORMATION</b>	<p><b>To release verbally or in writing:</b> Please check the following information to be released:</p> <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) <input type="checkbox"/> Treatment Plan <b>Any relevant medical information</b>	<p><b>To collect verbally or in writing:</b> Please check the following information to be collected:</p> <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) <b>Any relevant medical information</b>
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<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> _____ / _____ / _____                                      <b>Day                      Month                      Year</b></p> <p><b>Permission will expire on:</b> _____ / _____ / _____    <b>Day                      Month                      Year</b></p>
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<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> _____ / _____ / _____    <b>Day                      Month                      Year</b></p>
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THE FOLLOWING FORM SHOULD ONLY BE COMPLETED BY CALGARY & AREA PREGNANT OR PARENTING WOMEN



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 with 2 columns: WHAT INFORMATION, To release verbally or in writing, To collect verbally or in writing. Includes checkboxes for Assessment, Attendance, Treatment Plan, End-Summary & Recommended Actions, Program Dates, Progress Summary, Participation, Other (Specify): referrals and supporting documents, Progress Summary, Reason for Referral, Service Monitoring, Treatment Summary, Other (Specify): Health & safety concerns.

CONSENT section containing a statement of understanding, Client Signature, Witness, Date signed (MM/DD/YY), and Permission to expire on (MM/DD/YY).

CANCEL section containing a statement of cancellation, Client Signature, Witness, and Date signed (MM/DD/YY).



Application for Treatment

**GENERAL INFORMATION**

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

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

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



Application for Treatment

**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.

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

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

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 \_\_\_\_\_

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:**

AGENCY	REASON FOR TREATMENT	DATES	COMPLETION	
			YES	NO



Application for Treatment

**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.**

Name	Age	Sex	At Home?	Children's Services 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	

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: \_\_\_\_\_



Application for Treatment

**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



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 **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)

### 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)

### 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

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



## 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:**

### 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?  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

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/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. 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 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/>

**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.

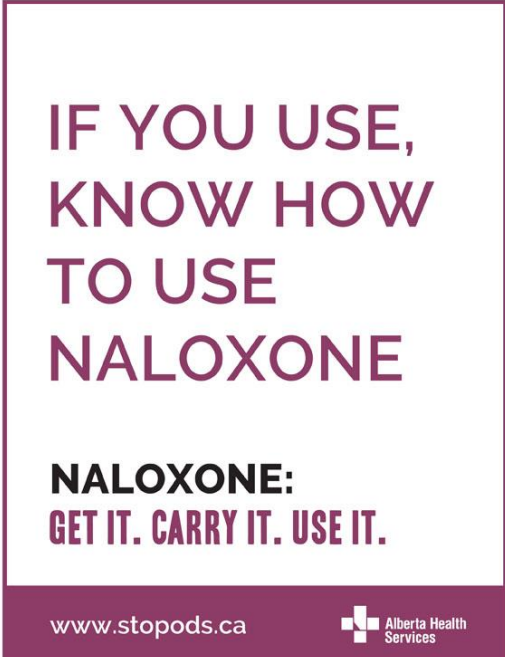
**Health Link** Call Health Link by dialing 8-1-1 for quick and easy advice from a registered nurse 24/7. They will ask questions, assess symptoms and determine the best care for you.

## 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**

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

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