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

Assessment & Admission Information	
Assessment & Assessment Fee Call 403-245-9050	**When you send in your application, please phone Aventa to book an assessment. You will need to pay the $40 assessment fee before your assessment appointment**. We accept Cash, Debit, e-Transfers, VISA, Mastercard, Bank Drafts, and Money Orders. **We do not accept personal cheques.** If a third party has agreed to pay this fee, Aventa requires confirmation of the information for invoice purposes. Please have the third party contact Aventa with their written agreement prior to your appointment. Aventa Staff can provide support options while Clients wait for treatment.
Confirmation of Treatment Call 403-245-9050	Once you are booked for treatment, you will be given a confirmation date 1 week prior to your admission. Please contact Aventa on this date before 4:00 pm to confirm your date of admission (a phone message is acceptable). **If you do not confirm, your bed may be given to another Client.**
Treatment Hours	Treatment groups run 6 days/week. All Clients are required to attend 12 Step meetings on Sundays.
Abstinence Prior to Treatment /To be Determined with Aventa staff dependent on drugs consumed	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.
Abstinence During Treatment	**All** Clients must refrain from gambling and using drugs and alcohol during treatment, and avoid licensed/gambling facilities. **If you use drugs, including restricted medications, alcohol or gamble during treatment, you will be discharged immediately.** Drug and alcohol screening will be required at the time of admission and anytime during treatment, at the discretion of Staff.
Prescription and Non Prescription (Over the Counter) Medications	All medications, vitamins (a regular multivitamin is permitted) 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.

Team Communication	Open communication occurs between all Aventa Counsellors, clinical practicum students, supervisors, and Medical Staff. Aventa strictly upholds Client confidentiality outside of the agency.
Visitation Hours	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.
Appointments	All appointments must be pre-approved by your Counsellor and are at Aventa's discretion. Please try to take care of all appointments before treatment.
Smoke-Free/Scent Free Centre	Smoking is only allowed outside and at designated times only. Counsellors and Medical Staff can provide assistance to Clients who want to quit smoking. Wearing perfumes/ scents is not allowed.
Phone Contact	Phone messages are not accepted. Clients have limited access to telephones. Long distance calls require a phone card. **Cell phones are NOT permitted. Please do NOT bring them to treatment.**
Fees for Treatment	**Payment is due prior to admission.** 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. 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. **Employee Assistance Programs** - If you have coverage through your Employee Assistance Program your fees may be covered through your plan. Please disclose this information during the assessment so we can start the process as soon as possible. **Self-Pay** – Please speak with our Assessments Department.
Transportation	Clients are responsible for arranging and paying for their transportation costs in order to attend Aventa, as well as throughout treatment. **Please do not bring your vehicle** as parking is not available.
Electronics	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:

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

WHAT INFORMATION	**To release verbally or in writing:** Please check the following information to be released: ☒ Assessment ☐ Attendance ☐ End-Summary & Recommended Actions ☐ Participation ☒ Program Dates ☐ Progress Summary ☐ Treatment Plan ☒ Other (Please Specify) **Any relevant medical information**	**To collect verbally or in writing:** Please check the following information to be collected: ☒ Assessment ☒ Attendance ☒ Relevant History ☒ Participation ☒ Other (Please Specify) ☒ Progress Summary ☒ Reason for Referral ☒ Service Monitoring ☒ Treatment Summary **Any relevant medical information**

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 this cancellation. **Client Signature: _____** **Witness: _____** **Date signed: _____ / _____ / _____** **Day Month Year** **Permission will expire on: _____ / _____ / _____** **Day Month Year**

CANCEL	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**

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.

WHAT INFORMATION	To release verbally or in writing:	To collect verbally or in writing:
	☒ Assessment ☒ Attendance ☒ Treatment Plan ☒ End-Summary & Recommended Actions ☒ Program Dates ☒ Progress Summary ☒ Participation ☒ Other (Please Specify): **referrals and supporting documents**	☒ Assessment ☒ Attendance ☒ Relevant History ☒ Participation ☒ Other (Please Specify): **Health & safety concerns** ☒ Progress Summary ☒ Reason for Referral ☒ Service Monitoring ☒ Treatment Summary

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

GENERAL INFORMATION

Name_____
Last First Middle

Maiden Name_____ Aliases _____
Last 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

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? _____

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

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
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ 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: _____

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

AVENTA
CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

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
- Water bottle with a lid
- Plain Analgesics (Advil/Aspirin/Tylenol) if required
- A regular multivitamin if required
- Craft supplies – No paint / glitter
- Writing paper, binder, pens/pencils, notebook
- Cigarettes

Optional:

- Alarm Clock
- Blow dryer, curling iron, straightening iron
- Spiritual items (Bible, smudging materials)

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:** _____

AVENTA

CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

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

AVENTA
CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

Confidential Pre-Admission Medical Assessment

The following details are to be completed by a medical professional, <u>not by the Client</u>. Please include NetCare information on the Client. Aventa is a non-medical, live-in treatment centre, so all physical and mental health information that can be provided is critical in planning for successful treatment.

Client Last Name:	**Client First Name:**
Alberta Health Care Number:	**Date of Birth:**
Family Physician's Name:	**Phone:**
Are you the Client's regular Physician? ☐ **No** ▸ ☐ **Yes**	
▸ ***If no,*** **regular Family Physician's Name:**	**Phone:**
Did you access NetCare to collaborate information for this medical? ☐ **No** ☐ **Yes**	
Has the Client ever seen a Psychiatrist? ☐ **No** ☐ **Yes** ▸	
▸ ***If yes,*** **Psychiatrist's Name:**	**When (Y-M-D)**

Does the Client have or has she ever been treated for:	**No**	**Yes**	**Please elaborate regarding details, severity and the impact on current functioning or how it might interfere with the Client's participation in programming and the treatment plan**
Allergies			
Ears/Eyes/Nose/Throat i.e.: Vision loss or problems, Hearing loss, Dental			
Endocrine i.e.: Diabetes, PCOS, Thyroid Disease, Obesity			
Gastrointestinal i.e.: Constipation, IBS, GERD, Crohn, Stomach/Duodenal Ulcers, Liver Disease			
Heart/Lungs i.e.: High Blood Pressure, Heart Condition, Asthma, COPD			
Infectious Diseases i.e.: Hepatitis, HIV/AIDS, MRSA, Tuberculosis Symptoms?			
Neurological i.e.: Seizures, Concussions, Head Injury, Migraines/Severe Headaches, Stroke, Dizzy Spells, Loss of consciousness			
Muscle/Joints/Orthopedics i.e.: Arthritis, Osteoarthritis, Fibromyalgia, Fractures, Pain (acute/chronic)			
Gynecological Menorrhagia, Dysmenorrhea, Contraception, Vaginosis, STI: (Last tested?) _____ **Pregnancy** Due Date _____			
Other Conditions i.e.: Cancer, Surgical History			
Mental Health i.e.: Eating disorder, Depression, Anxiety, Psychosis, ADD/ADHD, Personality Disorder, Suicide Risk/Attempt, Self-Harm Other _____			

AVENTA
CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

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
2. Physician stamp and signature * in a case where no Physician is available an alternative health care provider maybe accepted

Medication Name	Prescribing Doctor	Dose/Frequency	How long has Client been on this medication? Date prescribed (Y-M-D)	As treatment for what?

Restricted Medications: if a restricted medication is recommended by a Physician for a compelling medical reason, it will be considered on a case-by-case basis. A Restricted Medication Review Form, included in this medical, must be signed by Physician for any exceptions.

Medication Name	Prescribing Doctor	Dose/Frequency	How long has Client been on this medication? Date prescribed (Y-M-D)	As treatment for what?

Comments/Potential Side Effects

Medication Taper Plan

If you are aware of any concerns/issues that should be taken into account in the treatment of the Client, please indicate and give details

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's Signature	Date (Y-M-D)	Physician's Stamp
	Phone:	
	Fax:	

AVENTA
CENTRE OF EXCELLENCE FOR WOMEN WITH ADDICTIONS

Restricted Medication List
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, 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.)

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.

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Restricted Medication Review Form

The following details are to be completed by an Attending Physician, not by the Client.

Client Last Name:	**Client First Name:**
Alberta Health Care Number:	**Date of Birth:**
Family Physician's Name:	**Phone:**
Are you the Client's regular Physician? ☐ **No** ▸ ☐ **Yes**	
▸ ***If no,*** **how long have you known the Client? (Y-M-D)**	

On behalf of the above Client, permission is being requested to use a Restricted Medication while attending live-in addiction treatment at Aventa. Restricted Medications may pose a risk to sobriety due to their potential for abuse and must therefore be approved by Aventa medical team. **Please note that the completion of this form does not guarantee approval of the medication; all forms are considered on a case-by-case basis. Form needs to be completed in its entirety for it to be considered for review.**

Medication Name	**Prescribing Doctor**	**Dose/Frequency**	How long has Client been on this medication? Date prescribed (Y-M-D)	**As treatment for what?**

What non-restricted alternatives to this medication have been considered for treatment, and why are they not appropriate for treatment?

Any concern for potential misuse/addiction of this restricted medication for this Client?

Any other comments?

Physician's Signature	**Date (Y-M-D)**	**Physician's Stamp**
	Phone:	
	Fax:	

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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 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.

Mental Health Helpline provides toll-free, 24 hour telephone support, and offers help for mental health concerns for Albertans 1-877-303-2642

Distress Centre provides a 24 hour crisis line and free, face to face counselling in Calgary **403-266-HELP (4357)** http://www.distresscentre.com/

OVERDOSE - Reduce Your Risk

Fentanyl may be 100 times more toxic than morphine, heroin, oxycodone. Even small amounts can result in overdose and it can 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!**