

**Youville Recovery Residence for Women
APPLICATION FOR ADMISSION**

Check One: Phase I Phase I (Prenatal) Family Program Calgary Drug Treatment Court

Admission Completed by		Date:	
PERSONAL INFORMATION			
Last Name:		First:	Middle:
Address:		City:	Province: PC:
Home Phone No.:	Cell Phone No.:	Alternate Phone No.:	
()	()	()	
Marital Status:	Single <input type="checkbox"/>	Common Law <input type="checkbox"/>	Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
# of Children (if applicable)		Ages	
# of Children Living with Client		Other Dependents	
Highest Level of Education:			
Grade 1-9 <input type="checkbox"/>	Grade 10-12 <input type="checkbox"/>	Some Post-Secondary <input type="checkbox"/>	University Degree <input type="checkbox"/> College Diploma/ Degree <input type="checkbox"/> Other <input type="checkbox"/>
Date of Birth (m-d-y)	Age	Health Care Number & Province	Treaty Medical Services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Insurance No.	Treaty Services Card No.	Band Name & No.	Contact Person Phone No. ()
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your usual occupation?		Net Monthly Income? \$
If not employed, what is your current means of financial support?			
<input type="checkbox"/> Alberta Works	<input type="checkbox"/> EI	<input type="checkbox"/> Pension	<input type="checkbox"/> Self-Employed
<input type="checkbox"/> Aboriginal Funding	<input type="checkbox"/> AISH	<input type="checkbox"/> Trustee	<input type="checkbox"/> Federal Tax Benefit
<input type="checkbox"/> Company Benefits	<input type="checkbox"/> Child Maintenance	<input type="checkbox"/> Other, Specify	
If you receive Alberta Works Assistance, Name of Financial Benefits Worker			Phone No. ()
Ethnicity: Do you define yourself as (choose all that apply):			
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Aboriginal-Non Status	<input type="checkbox"/> Aboriginal (Treaty Status)	<input type="checkbox"/> Inuit (Status)
<input type="checkbox"/> Indian	<input type="checkbox"/> African / Black	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Latin American
<input type="checkbox"/> Metis	<input type="checkbox"/> Other (Specify)		
Next of Kin / Emergency Contact:			
Last Name		First	Relationship
Address:		City:	Province: PC:
Phone No.:		()	Secondary Phone No.: ()
During my treatment at Youville Residence Society of Alberta, I _____ give Youville permission to contact the above next of kin/emergency contact in case of emergency or in the event of discharge.			
Signature		Witness	
Date Signed (m-d-y)		Date Signed (m-d-y)	

OFFICE USE ONLY	
Today's Date	Admission Date
Type of Treatment	Method of Payment
Drug & Alcohol	Self
Gambling	Social Services
Other (sex, shopping, etc)	Child Welfare
Program	Application Completed by:
Residential	Referring Party
Outpatient	Self

Gambling Addiction History

Please list the types of gambling (past and present) you have participated in. Please include: bingo, VLT's, slots, internet, casinos, scratch tickets, cards, lotteries, racing, etc.

Type of Gambling	Amount of Money Spent	Pattern of Use (daily, weekly, etc.)	Last Gambled

How long have you been gambling?

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

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

Please list any gambling withdrawal symptoms you have experienced.

How long have you been able to abstain from gambling?

Other Addiction History

Do you identify patterns in other areas of your life that may have addictive qualities?

Internet Relationships Shopping Sex Food Money 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?

Have you experienced any withdrawal symptoms? Yes No

If yes, please list all withdrawal symptoms you have experienced.

Smoking Addiction History

Do you currently smoke cigarettes? Yes No Are you interested in quitting? Yes No

Please describe your pattern of use.

How has your addiction affected the following areas of your life?

Family

Emotional

Social

Physical (including withdrawal symptoms you experience)

Work / School

Spiritual

RESOURCES

What do you see as your resources and resiliencies?

Faith
 Community
 Counsellors
 Family
 Friends
 Other _____
 Other _____

What gives you hope?

What do you see as your personal strengths?

What are some of your goals?

- 1.
- 2.
- 3.
- 4.
- 5.

What are some of your passions?

PRIOR COUNSELLING / TREATMENT HISTORY

Have you ever received counselling for your addiction problem? Yes No

Have you ever attended any substance abuse programs? Yes No

Date	Name of Program	Where	Completed
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you attended any self-help groups? Yes No

Please check which one(s) AA NA CA SAA Other: _____

Previous Treatment

Have you previously been assessed or received treatment at Youville Recovery Residence for Women? Yes No

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

Why or why not?

Please list other addiction treatment or detox programs.

Agency	Reason for Treatment	Dates	Completed
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Parenting / Family Status

Are you currently pregnant? Yes No If yes, specify due date or # months pregnant

Have you received prenatal care? Yes No

Please list all children (if applicable)

Name (First and Last)	Age	Sex (M/F)	At Home? (Yes/No)	Placed Where?	Child Welfare Status* TGO, PGO, CA, SA, SO

***Status Key** TGO = Temporary Guardianship Order, PGO=Permanent Guardianship Order, CA=Custody Agreement
SA=Support Agreement, SO=Supervision Order

Children’s Services Involvement

Is addiction treatment a requirement as set out by Child Welfare? Yes No

Are you currently working with a Child and Family Services Worker? Yes No

Case Worker’s Name: _____ Location: _____

MEDICAL / PSYCHIATRIC HISTORY

Do you have any medical problems? Yes No

If yes, please explain.

Are you presently on any medication? Yes No

Name of Current Family Doctor _____ Phone No. ()

Do you have any medical limitations that could limit your participation in the program activities or chores? Yes No

If yes, please explain.

Do you require any special dietary considerations? Yes No

If yes, please explain.

Do you have any allergies? Yes No

If yes, please explain.

Do you have any eating disorders? Yes No

If yes, please explain.

Have you ever been under psychiatric care? Yes No

If Yes, when? _____ Where? _____

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

Please indicate dates and circumstances:

Psychiatrist _____ Phone No. ()

Mental Health Worker _____ Phone No. ()

Other Professional Contacts _____ Phone No. ()

Name of Psychiatrist _____ Phone No. ()

Other Relevant Information:

Please place a circle indicating whether you have any of the following health problems or diseases (now or in the past).

Seizures	Diabetes	Heart Problems	Stroke	Allergies
Eating Disorders	HIV/AIDS	Hepatitis	Blood Disorders	Cancer
Respiratory Problem	Fibromyalgia	Vision Problems	Hormone Problems	Ulcers
Liver Problem	Tuberculosis	Arthritis	Osteoporosis	Lupus
Skin Problems	Thyroid Problems	Chest Pains	Dizziness	Other: _____

Please list physical conditions (e.g. migraines, dental, chronic back pain, withdrawal symptoms) that may impact participation in treatment or require medical follow-up during treatment and for how long.

Please describe any accidents or injuries you have had, indicating the year of the accident(s).

Have you recently had any health symptoms that you are concerned about or would like some information on. Please describe.

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

Do you currently (i.e. within last 6 months) have any of the following eating behaviours?

Binge Eating Laxative/Enema Abuse Eating Restrictions Diuretic Abuse Vomiting/Purging Excessive Exercising

Physician _____ Phone No. () _____ Office Location: _____

Have you engaged in high-risk sexual activity? Yes No

Have you ever been involved in the sex trade? Yes No

Please list all medications you are currently taking, including over the counter drugs, natural products and vitamins.

Medication	Dosage	Reason for Use	Start Date	End Date

Please list the date of your most recent physical exam (m-d-y)

Do you require a medical exam at this time? Yes No

Mental Health Information

Are you currently with a mental health professional? Yes No

If yes, name: _____ Phone () _____ Fax () _____

Please specify (e.g. psychiatrist, psychologist, therapist)

Please circle indicating whether you have ever been diagnosed with any of the following mental illnesses.

Depression	Anxiety (panic disorder, agoraphobia)	Bi-polar
Personality Disorder	Borderline Personality	Obsessive-Compulsive Disorder
Attachment Disorder	Post Traumatic Stress Disorder	Attention Deficit Disorder
Manic Depression	Cognitive Impairment (dementia, brain injury)	Other: _____

Do you agree with the diagnosis? Yes No Why or why not?

Please circle indicating whether you have any of the following concerns.

Poor Memory	Concentration Problems	Confusion	Hallucinations/Delusions
Anxiety	Forgetfulness	Poor Attention Span	Hyperactivity
Mood Swings	Fears	Phobias	

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

Please indicate the dates and reason for hospitalization.

Have you had any of the following health risk behaviours currently or within the last six months?

	Frequency	Last Time	How Managing
Seizures			
Suicidal thoughts or attempts			
Self-inflicted violence			
Hospitalization for psychiatric illness			

Please indicate the dates and circumstances.

Are you having any mental health symptoms that you would like help with. Please describe.

COURT / LEGAL INFORMATION

Do you have a criminal record? Yes No If yes, please use back of page to list offences.

Do you have any pending traffic, civil or criminal cases? Yes No

Charges _____ Court _____

Date(s) _____ Where _____

Legal History

Please select all that apply. If yes, please use back of page to list.

Do you have a history of violence? Yes No

Possession, trafficking of narcotics? Yes No

Current legal involvement? Yes No

Are you currently on parole or probation, incarcerated or under house arrest? Yes No

Are you on day parole / temporary absence / conditional sentence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Probation / Parole Office / Case Worker Name	
Phone ()	Fax ()
Do you have any outstanding legal charges?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Copy of document is provided
If yes, please describe	
Upcoming court date(s) (m-d-y)	
FAMILY AND SOCIAL HISTORY	
(If you require additional space, please use the back of this form)	
Family History	
Is there an addiction in your family? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify who and what below.	
Who?	What Addiction?
Briefly describe your relationship with your parents/caregivers while growing up and at the present.	
Social History	
Have you experienced any of the following types of abuse?	
<input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual <input type="checkbox"/> Financial <input type="checkbox"/> Other: _____	
Is this the first time you have talked about this? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please describe significant life losses.	
Death / loss of a child	
Loss of job	
Divorce/separation	
Death of family member	
Health problems	
Other (describe)	
Please list all support you have (e.g. 12/16 Step, Family, Friends, Church, Community Agencies, etc.).	

I hereby declare that, to the best of my knowledge, the information contained herein is true and that upon my admission, I agree to abide by any and all rules of Youville Residence Society of Alberta and to notify the staff of any changes in the information contained herein. I also give consent to Youville Residence Society of Alberta to use this information to interact with other agencies as required for purposes of admission and ongoing residency. I also understand that knowingly submitting false information on this application is grounds for voiding this application or dismissal from Youville Residence Society of Alberta.

Signature _____ **Date** _____

CONSENT: For Release and Collection of Confidential Information

I, _____, Resident/Client, D.O.B. (mm/dd/yy) ____/____/____
 (please print)

- OR -

I, _____, the Guardian or Agent or Personal Representative, for the
 (please print) (please circle applicable designation)

Resident/Client named above hereby give my consent to the Youville Recovery Residence for Women to contact:

TO / FROM	Organizations: Alberta Health Services, including but not limited to: Child and Family Services Emergency Medical Services Rocky View Hospital Sheldon M. Chumir Health Centre Foothills Hospital Peter Lougheed Hospital Mobil Response Team Calgary Urban Project Society (CUPS) Any and all agencies or partners associated with Youville Recovery Residence for Women for the purpose of treatment/programming.
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WHAT INFORMATION	To release verbally or in writing: Please circle the information to be released: Assessment Participation Attendance Program Dates Summary & Progress Summary Recommended Actions Any and all relevant Treatment Plan medical information Other (please specify): _____	To collect verbally or in writing: Please circle the information to be collected: Assessment Progress Report Attendance Reason for Referral Relevant History Service Monitoring Participation Treatment Summary Any and all relevant medical information Other (please specify): _____
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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. Resident / Client Signature: _____ Guardian / Agent/ Personal Representative: _____ Witness: _____ Effective Date: _____ Expiration: _____
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CANCEL CONSENT	By my signature below, I cancel the permission given above. I understand that some action may have been taken prior to this cancellation. Resident / Client Signature: _____ Guardian / Agent/ Personal Representative: _____ Witness: _____ Effective Date of Cancellation: _____
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CONSENT FORM: Health / Medical Information Release

I, _____, Resident/Client
(please print)

- OR -

I, _____, the Guardian or Agent or Personal Representative, for the
(please print) (please circle applicable designation)

Resident/Client named above hereby give my consent to and authorize the release of the following health / medical information contained in:

- Diagnostic, Treatment and Care Information
- Registration Information
- Health Services Provider Information
- Case Notes, Shift Reports, Incident/Critical Incident Reports
- Other (Specify) _____

This consent applies to any personal or health information, records or knowledge about me that can be given to the Director(s) of Programs, or to their designate acting for me, for the purpose of my personal file at the Youville Recovery Residence for Women. This information may be obtained from any person, organization or institution, including, but not limited to, any of the following: physicians or other health care practitioners or providers, hospitals, clinics or other medically related facilities, clergy and investigation agencies.

I understand that this authorization is required in order to assess my suitability for the Youville Recovery Residence for Women program. I further understand that if I am a successful applicant, a review of all documentation may take place during my time in the program, in order to make sure that the program is identifying my areas of need while in the program and that I continue to meet all the requirements of the program.

I acknowledge that I have been made aware of why my health information or the health information of the individual I am authorized to sign for is required and the risks and benefits to myself, or the individual I am authorized to sign on behalf of.

I agree that a copy of this signed Consent for Health/Medical Release for Youville Recovery Residence for Women is as valid as the original.

I understand that I may revoke this consent at any time by signing a Consent Revocation: Health/Medical Information Release form. This form shall be made readily available.

Resident / Client: _____

Guardian/Agent/Personal Representative: _____

Witness: _____

Date: _____

I, _____, understand that my treatment and any information I may share at Youville Women’s Residence Society is confidential and that any release of information shall require a signed release from me.

I further understand the following limits of confidentiality:

Youville 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 Youville is legally obligated to do so (i.e. 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 Youville staff share information to assist them in delivering the most effective treatment.

Resident / Client: _____

Date: _____

Witness: _____

Date: _____

Dear Attending Physician:

Your patient has applied for admission to Youville Recovery Residence for Women. The Centre provides an intensive group treatment program for addictions for up to 7 months.

The Centre is a non-medical facility; so all clients must be medically stabilized and detoxified prior to admission. During treatment, emergency care is available on a 24-hour basis through hospital emergency departments off site. It is expected that clients admitted to our program be able to participate mentally, emotionally, and physically in the intensive program without the need for ongoing medical care.

Please fill in the accompanying medical form with as much detail as possible including all prescribed and over the counter medications your patient is presently taking prior to admission. We require as much medical history as possible in order to accurately assess the ability of the client to participate in treatment.

Your patient is responsible for any fee you charge for this service.

Clients being treated at Youville must have completely withdrawn from alcohol and drugs and have a 10 day period of abstinence prior to entry into the program. Potentially addictive medications such as opiates, benzodiazepines and barbiturates are not allowed. Please ensure that any medical conditions such as chronic pain syndrome and migraines are well controlled without the need of medications. We do admit clients stabilized on methadone therapy. If adjustments need to be made to medication(s), please ensure this is done one month prior to admission to treatment.

All medication must be listed and approved prior to treatment. If there are any changes prior to admission into treatment a new form must be completed or an amendment made to the initial form and signed by the original attending physician.

If special circumstances exist, please forward information on the medication in question for review by our clinical director. Other inappropriate referrals to Youville include persons with the following disorders:

- Paranoid and other fixed delusions
- Auditory, visual, olfactory, or kinesthetic hallucinations
- Suicidal ideation
- Other thought disturbances which seem out of the person's control and not accessible to efforts for change

Previous experience indicates these conditions impair the ability of the client to form functional relationships with other clients and staff; it usually leads to failure to complete the program. If in doubt, please contact Youville for further discussion about your patient's needs.

If you become aware of any reason why your patient would not be appropriate for the program, please inform us as soon as possible. Our telephone number is (403) 242-0244.

Thank you for completing the attached form. Please fax to: (403) 242-3915.

Sincerely,

Cheryll Nandee
Executive Director

MEDICAL ASSESSMENT FORM

This form must be completed by a physician. The cost of the health questionnaire is the responsibility of the client. This information is being collected under the authority of the Alberta Alcohol and Drug Abuse Act.

Date (m-d-y)		Patient Name:	
DOB: (m-d-y)		Occupation:	
Address:			
Medical History			
Psych History			
Surgical History			
Medications			
Allergies (Please specify):			Anakit
Dietary Requirements			
DRUG HISTORY			
	Name of Drug	Date of Last Use	
Alcohol			
Cannabis			
Cocaine			
Amphetamines (including crystal meth)			
Benzodiazepines			
Other			
Other			
PHYSICAL EXAMINATION			
Height	Weight	BP	Pulse
ENT		CHEST	
CVS		ABD	
NEURO		M/SK	
SKIN		ENDO	

Patient Name: _____

HISTORY	YES	NO	Comments (Explain YES responses)
Drug and Alcohol Abuse or Addiction			
Mental Health Disorders			
Eating Disorder			
Sleep Disorder			
Nervous Disorders			
Urinary tract disorders			
Hepatic Disorders (Hepatitis, HBV, HCV)			
Circulatory system Disorder			
Reproductive System Disorder			
Respiratory System Disorder			
Gastrointestinal Disorder			
Pancreatic Disorder (diabetes)			
Pain- Chronic, Acute			
Suicidal Tendencies			
Attempted Suicide			
Seizures			
STD's including HIV, AIDS			
Liver Function Test			
Other Health Related Problems			
Blood Pressure _____ / _____			
Blood Sugar _____			
Weight Loss _____ lbs Time Span _____			
Calcium Level:			
Zinc Level:			
Magnesium Level:			
B12 Level:			
Vitamin D Level:			
Fatigue			
Night Sweats			
Fever			
Blood in Sputum			
Cough Lasting Longer than 2 weeks			
Exposure to Tuberculosis			
Chest X-Ray Results			
Birth or Travel to Place with High Incidence of Tuberculosis			
Previous Treatment for Tuberculosis			
Poor General Health Status			
Chronic Medical Conditions			
Possible Risk Factor for Progression of Disease			
Further Screening Required			
Further Assessment Required			
Other Risk Factors for Infection			
Pregnancy (if yes # of months)			
Disabilities			
Eyesight Problems			
Dental Problems			

Client is medically and physically able to participate in an intensive group-counseling program.

Physician Name _____ Physician Signature _____ Date _____

Thank you for completing the attached form. Please fax to 403 242-3915

Youville Recovery Residence for Women
3210 – 29 Street SW Calgary, AB T3E 2L1
Telephone (403) 242-0244 Fax: (403) 242-3915
Email: intake@youville.net
www.youville.net

Your Pre-admission Checklist

- Contact Youville Recovery Residence for Women
- Submit your admission package
[Fax: (403)242-3915] or mail to: 3210–29 Street SW, Calgary, AB T3E 2L1
- Fax agreement / confirmation of payment for residential treatment
- Pay non-refundable Assessment Fee of \$40.00
- Inform Youville staff of your arrival time and method of transport
- Have medical form completed by your doctor (if you have not had an attending physician for a year a visit can be scheduled with our medical provider prior to admission)

Please read the full admission package prior to submitting to us.

We would like to remind clients and referring Agents that clients are in retreat for up to one month during which time there are no visitors or telephone contacts.

Admission Criteria

- Females only: must be 18 years of age or over.
- Must be clean and/or sober ten days prior to admission.
- Free from mood-altering substances such as benzodiazepines, codeine, and barbiturates.
- Medically able to participate in the program (doesn't have current physical health problems that would prevent participation in group sessions for example acute back problem, migraines or tooth pain).
- Emotionally and physically able to participate in programming.
- Able to defer any pending court dates until after treatment.
- Established in community for two months post-incarceration.
- Able to understand and verbally communicate.
- Committed to making changes in life

Things **to bring** (see complete list attached):

- Government Photo ID
- Comfortable (non revealing) clothes
- Gym wear
- Bath robe
- Indoor shoes (slippers, runners, etc.)
- Outdoor shoes (walking shoes, runners)
- Bathing suit (non revealing one piece suits)
- Sunscreen
- Feminine products and toiletries (*not containing alcohol* such as mouthwash, etc.)
- Seasonal outerwear
- Spiritual or recovery based reading material
- Phone cards for long distance calls

Things not to bring:

- Cell phone, ipod, camera, MP3 player
- Drug paraphernalia
- Snacks, candies, pop, energy drinks
- Knives (including pocket knives)
- Laptops/computer, blackberry devices (no electronic devices)
- DVD players and movies
- Lottery or scratch tickets
- Pornography
- Perfumes, body mists, etc.
- Revealing clothing (including bikini's), or clothing promoting drug or alcohol use
- Recreational reading material
- Sexual devices
- Non-prescription vitamins, supplements, protein powders (vitamin B, Omega 3-6-9).

Note: This is not an exhaustive list. Other items may be removed at the discretion of staff members.

Laundry Facility

Laundry is available at no charge.

Telephone

Clients will be on retreat for up to four weeks. This means there will be no outside contact during this time. Following the retreat period, clients will have access to make outgoing calls only. Messages received for clients will be relayed through their respective counsellor.

Visitors

Visitors are only able to be on Youville premises for graduation, open houses and events by special invitation only. Some restrictions may apply.

Mail

The mailing address for all letters and packages is:

3210 - 29 Street SW
Calgary, Alberta T3E 2L1

All mail including packages must be opened in the presence of a staff member.

Client Responsibilities

Clients will be assigned chores during the course of their stay and will be expected to keep their rooms and the facility clean.

Miscellaneous

Fees for treatment are determined on a sliding scale basis on income verification or they may be covered by a third party, e.g. AEII, Child and Family services, Employment Assistance programs, etc. This will be determined at the time of assessment. Payment is due prior to admission. No refunds are given.

Youville is a smoke free/scent free centre. Smoking is only allowed outside and at designated times. Staff are available to help clients who wish to quit smoking. Wearing perfume or any scents is not allowed.

Treatment

Included in your treatment fee is; individual and group counseling, participation, aftercare support, comfortable accommodations, laundry services, balanced nutritious meals. Treatment groups run every day. Clients are expected to participate in all groups and meetings.

Detoxification

Clients are required to remain drug and alcohol free for 10 days prior to treatment. This allows the client to be more attentive and ready to begin treatment upon arrival. Clients who have not been sober for 10 days, may be required to remain offsite at a detoxification clinic before beginning treatment at Youville.

Medication

All medication must be in its original packaging. All bottles and containers must be with original labels and complete information provided.

Upon admission, medications will be forwarded to the local pharmacy to be bubble packed. Medications will be delivered bubble packed weekly during the clients stay.

Physicians will be required to forward all new prescriptions and renewals to the designated pharmacy.

What to Expect at Admission

- All paperwork (already completed) will be reviewed and gone over.
- Your photo will be taken as well as copies of your health care card and other important documents.
- A drug and alcohol test will be performed. You will be required to pass this before admission. If it appears diluted, you may be asked to retake the test in one hour.
- All bags will be searched. Prohibited items will be confiscated (please note there are no storage facilities on premises). Weapons will be discarded; if considered illegal, they may be handed over to the Calgary Police Service.
- A tour of the facility and an orientation will be provided.
- You will be assigned your room and a buddy.
- You will meet the treatment staff.