Kackaamin
FAMILY DEVELOPMENT CENTRE

11/24/2022

Kackaamin
FAMILY DEVELOPMENT CENTRE

# Adult Intake Application

**OVERVIEW:**

******This Application is to be completed and reviewed together by applicant families and referral workers. ******

******Intake package must be received by Kackaamin in FULL prior to review by intake committee. Incomplete packages will be held in cue, but will not be considered for admission until all required portions are received. ******

******Please ensure the "Intake Checklist" found on our website or requested by email from the Intake Coordinator- to be completed with EACH adult applicant and submitted with EACH adult intake application. ******

******Please ensure a medical for each adult applicant (forms found within this application) is completed and signed off by a medical physician/ nurse practitioner and submitted with each adult application. ******

******Each adult applicant MUST attach a copy of TB test results to their application to be considered for admission. ******

******Children must be up-to-date on immunizations to attend our facility and must submit immunization records with their applications. ******



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# Adult Intake Application

| **GENERAL INFORMATION** | | | |
|---|---|---|---|
| DATE OF APPLICATION: | | | |
| Last Name: | First Name: | Alias: | |
| Date of Birth (YYYY/MM/DD):<br>/ /<br>Self-identified Gender: | Telephone: | Mobile: | |
| Email Address: | Other: | | |
| Address: | City: | Province: | Postal Code: |
| Aboriginal Ancestry<br>❑ YES ❑ NO | Band Name:<br>Band Number: | On Reserve ❑<br>Off Reserve ❑ | |
| Personal Health Number: | | | |
| Emergency Contact: | Telephone: | | |
| Relationship to Client: | | | |

**FAMILY RELATIONSHIPS**

Current Living Arrangements:

❑ With my family ❑ With extended family ❑ With parent(s) ❑ With friend (s) ❑ Alone ❑ As part of a couple
❑ As a single parent ❑ With partner and kid(s) ❑ Alone ❑ Recovery Home ❑ Homeless ❑ Shelter
❑ Other (*specify):*

| Marital Status*:* | ❑ Married | ❑ Common-Law | ❑ Single | ❑ Separated<br>❑ Co-Parenting | ❑ Widowed | ❑ Divorced |
|---|---|---|---|---|---|---|

| | | | |
|---|---|---|---|
| Is MCFD or DAA involved at any level? | ❑ YES ❑ NO | If yes, please describe: | Most recent Family Plan attached?<br>❑ YES ❑ NO |
| Are any of the children in care? | ❑ YES ❑ NO | If yes, please describe: | Most recent Family Plan attached?<br>❑ YES ❑ NO |
| Does the client have other children? (e.g. adults, not living in home) | ❑ YES ❑ NO | If yes, please describe: | |



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| | | | |
|---|---|---|---|
| Does the applicant have any outstanding child custody issues? | ❑ YES ❑ NO | If yes, please describe: | |
| Does the applicant have a no-contact order with his/her partner? | ❑ YES ❑ NO | If yes, please provide date order came into effect: | |

| Dependent Child (ren): *First and Last Name*: | Age: | Relationship to Applicant: | Consent to attend treatment: *(signature required)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| *(For children in care or living with other family members)* | Is the intention of attending treatment to have children returned to client at the end of the Family Session?<br>❑ Yes ❑ No ❑ Not Applicable |
| | Is there a supervision order from a family protection agency?<br>❑ Yes ❑ No ❑ Not Applicable<br>***(Please attach supervision order/document)*** |
| | Is there a safety plan from a family protection agency?<br>❑ Yes ❑ No ❑ Not Applicable<br>***(Please attach safety plan)*** |

Are there any physical challenges or chronic health conditions that require special attention in any member of your family? *Please specify*

Will the client require any assistance with reading or writing? ❑ Yes ❑ No

*Additional Information:*



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| | |
|---|---|
| FAMILY SUPPORTS: | |
| FAMILY STRENGTHS: | |

**FUNDING RESOURCES:**

1. How is treatment being paid for? (E.g. FNHA, Band, MCFD, self, etc.?)
2. Does the applicant have funding for travel to and from treatment? ❑ Yes ❑ No
3. Have travel arrangements been made? ❑ Yes ❑ No
4. Is client aware that Kackaamin does not provide food while at treatment for 6-weeks? ❑ Yes ❑ No
5. Does the applicant have funding from an outside agency for groceries while here? ❑ Yes ❑ No (e.g. MCFD, Nation, Income Assistance, etc.)
6. Is the applicant paying for their own groceries with their own income? ❑ Yes ❑ No

*****ALL FUNDING RESOURCES MUST BE IN PLACE PRIOR TO ATTENDING*****

**EMPLOYMENT HISTORY**

| Source of Income: | ❑ Job | ❑ Income Assistance | ❑ Disability Income |
|---|---|---|---|

Please select all that apply:

❑ Full time ❑ Seasonal ❑ Retired ❑ Student
❑ Part Time ❑ Temporary ❑ Self Employed
❑ Permanent ❑ Unemployed ❑ Training

**EDUCATION STATUS**

(Please check the highest level of education)

❑ Elementary (Grades 1-8) ❑ College/Post-Secondary
❑ High School (Grades 9-12) Did client graduate High School? ❑Yes ❑ No
❑ Trade School (e.g. hairdressing, carpentry)
❑ Adult Dogwood Certificate ❑ University (Bachelor Degree, Masters)

**LEGAL STATUS**

Does the applicant have a history with the legal system? ❑ Yes ❑ No
*If yes, complete this section in full. If no, please move on to next section.*

Are there any previous charges or convictions? ❑ Yes ❑ No
If yes, please provide dates:



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If yes, were charges (select all that apply):
❑ Violent ❑ Sexual ❑ Drug-related ❑ Involved a minor ❑ Involved a partner

Are there any current legal orders or legal involvement in place for any reason? ❑ Yes ❑ No
If yes, please describe:

If yes, were charges (select all that apply): ❑
Violent ❑ Sexual ❑ Drug-related ❑ Involved a minor ❑ Involved a partner

Is the applicant currently: ❑
On Parole ❑ Serving a Probation Order ❑ Bound by Release Order/ Undertaking (Bail Order)

If yes to either of the above, please provide:

| Parole/ Probation/ Bail Officer Name | P/P/B Officer Telephone | P/P/B Officer Email |
|---|---|---|
| | | |
| Address | City, Province | Postal Code |

**Consent for the Release of Confidential Information:**

I, (please print applicant name)_____ hereby give permission for the intake staff at Kackaamin Family Development Center to contact my referral worker and my Bail/Probation Officer for the release of pre-treatment information, disclosure of progress during treatment and aftercare planning and final discharge report if requested.

_____ _____
Applicant Signature Date

Are there any Pending Charges? ❑ Yes ❑ No
If yes, please describe:

If yes, were charges (select all that apply):
❑ Violent ❑ Sexual ❑ Drug-related ❑ Involved a minor ❑ Involved a partner

List any upcoming or pending court dates:

*****The client must not have any upcoming legal issues/court cases during their stay at KFDC.**
**ALL court dates must be dealt with prior to admission to Kackaamin Family Development Centre.**

*****A copy of the Parole/Probation/Bail Order must be included with the application for treatment before it will be reviewed by the KFDC Intake Committee.**

## TREATMENT HISTORY AND NEEDS-MENTAL, EMOTIONAL, PHYSICAL AND SPIRITUAL:

1. Have you participated in community-based substance abuse, mental health programs, or healing programs?
❑ Yes ❑ No
List Programs: _____
_____



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| 2. **Have you attended the following:** | | **Required to participate in the following while on site:** |
|---|---|---|
| Alcoholics Anonymous | Yes ❑ No ❑ | Alcoholics Anonymous/12-step programs |
| Narcotics Anonymous | Yes ❑ No ❑ | Narcotics Anonymous |
| Other Step programs | Yes ❑ No ❑ | |
| Co-dependents Anonymous | Yes ❑ No ❑ | |
| Self-help | Yes ❑ No ❑ | |
| Cultural Activities | Yes ❑ No ❑ | |

3. Have you participated in a residential treatment program? ❑ Yes ❑ No

If yes, please provide previous treatment history:

| Treatment Centre | Type of addiction treated | Year | Completed |
|---|---|---|---|
| | | | ❑ Yes ❑ No |
| | | | ❑ Yes ❑ No |
| | | | ❑ Yes ❑ No |

4. Are you receiving counselling from any counselling resources? ☐ Yes ☐ No
If "Yes", how many counselling sessions in the last 3 months? _____

5. If "No", will you be seeing a counsellor prior to treatment? _____

6. List of other Counsellors, Social Workers or other professional services that are being utilized: (Name, Phone Number):

*****PLEASE HAVE COUNSELLORS INVOLVED COMPLETE "Counselling Summary and Involvement Form" and attach to this application*****

7. **Have you been hospitalized because of substance misuse?** Yes ❑ No ❑
If "Yes", please list date/s: _____

8. Have you ever been hospitalized for a mental illness by a medical professional? Yes ❑ No ❑
*Attach assessment if available.*

9. Does the applicant have a history or have they ever been diagnosed with a mental illness by a medical professional?
Yes ❑ No ❑ *If yes, please select all that apply:*
❑ Depression ❑ Anxiety/ Panic Disorders ❑ ADD/ADHD ❑ Brain/ Head Injury ❑ FAS/ FAE ❑ PTSD
❑ Military/ First Responder PTSD ❑ Other: _____

10. Does the applicant have a history of: ❑ Suicidal Ideation ❑ Self Harm
Has the applicant ever attempted suicide? ❑ Yes ❑ No If *yes, when was the last attempt?*



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11. Did the applicant attend Indian Residential School? ❑ Yes ❑ No

12. Is the applicant an intergenerational survivor of Indian Residential School? ❑ Yes ❑ No

13. Does the applicant have any chronic or acute medical issues that could affect their participation in the program?
❑ Yes ❑ No, please provide details:

14. Does the applicant have any special needs that the treatment center should be aware of? (E.g. visual impairments, hearing aids, etc.)
❑ Yes ❑ No, please provide details:

15. Does the applicant have any physical disabilities that the treatment center should be aware of? (E.g. require wheelchair accessible rooms, etc.)
❑ Yes ❑ No, please provide details:

16. Please share and spiritual or cultural involvement that the applicant takes part in:

17. Is the applicant willing to respect First Nations healing practices and incorporate spirituality into their healing (e.g. Sweat Lodge, Cedar Brushing, Pipe Ceremony, etc.)?
❑ Yes ❑ No



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| **SUBSTANCE USE HISTORY:** | | | | |
|---|---|---|---|---|
| *Please circle primary drug(s) of choice* | | | | |
| Drug Type | Est. Age of First Use | How Often (rarely, occasionally, weekly, daily) | Amount/ Quantity Used | Date of last use |
| Alcohol | | | | |
| Amphetamine | | | | |
| Cannabis | | | | |
| Crystal Meth | | | | |
| Crack Cocaine/ Cocaine Powder | | | | |
| Hallucinogens | | | | |
| Heroin | | | | |
| Inhalants | | | | |
| Opiates | | | | |
| Opioid Agonist Therapy | | | | |
| Prescription Drugs | | | | |
| Tobacco | | | | |
| Process addiction (e.g. gambling, eating) | | | | |
| Other (specify): | | | | |
| Other (specify): | | | | |



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## REFERRAL INFORMATION
*(COMPLETED BY REFERRAL WORKER)*

Referral Worker/Counselor Name: _____

Title: _____

Agency: _____ Tel #: _____ Cell #: _____

Fax #: _____ Email: _____

Address: _____

1. Has the client completed pre-treatment appointments? ❑ Yes ❑ No

Please list dates: (*YYYY/MM/DD*)

_____/_____/_____ | _____/_____/_____

_____/_____/_____ | _____/_____/_____

_____/_____/_____ | _____/_____/_____

1. Is the client receiving counselling from you? ❑ Yes ❑ No

*****If yes- please review and complete "Counselling Summary and Involvement"- addendum to this application.**

Client Authorization

*I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by Kackaamin Family Development Centre.*

_____ _____
Client Signature YYYY/MM/DD

_____ _____
Referral Signature YYYY/MM/DD



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## INFORMED CONSENT

I, (Client's Name, PLEASE PRINT) _____, consent to attend KFDC and have reviewed the following points with my Referral Worker and initialed as confirmation of my understanding of the following points:

1. ____ I consent to the Intake Coordinator contacting referral agencies, such as Probation Officers, Medical Practitioner's, Social Workers etc. to obtain clarification on information included in this application for treatment.
2. ____ I understand if I have legal issues, a copy of the probation order must be submitted with the application for treatment, and **ALL** pending court dates must be dealt with prior to admission to KFDC.
3. ____ I understand the Intake Coordinator will notify my referral worker by letter to confirm my acceptance to treatment.
4. ____ While in treatment, I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.
5. ____ If on provincial assistance, I agree the Intake Coordinator can release confirmation of my intake and discharge dates to my Employment and Assistance Worker.
6. ____ I understand the importance of being free from and have taken care of all outside business, which will take my attention away from the treatment program.
7. ____ I understand if I am discharged or voluntarily leave treatment I am responsible for return travel. I will be arriving at treatment with my return travel arrangements in place.
8. ____ I understand that if I abuse substances while in treatment it may result in my immediate dismissal from the program, with recommendations to a different "Individual" treatment program.
9. ____ I understand that Kackaamin staff engages in case conferencing for the benefit of treatment and healing.
10. ____ If accepted, I consent for the Counsellor to confer with my probation officer, if applicable, regarding my progress and clarifying any details.

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**Consent to Release Confidential Information**

I, *(Client's signature)* _____ hereby give permission for KFDC staff to contact the referral worker(s) listed below for the release of information in regard to pre-treatment conference call, process during treatment, aftercare planning, and Final Discharge Report.

I, *(Client's signature)* _____ release KFDC from any casual liability in the event that my personal vehicle is damaged or stolen while parked KFDC property.

REFERRAL WOKERS NAME: _____
ORGANIZATION/AGENCY NAME: _____
ADDRESS: _____ CITY: _____
POSTAL CODE: _____ EMAIL: _____
BUSINESS PHONE: _____ FAX: _____
ALTERNATE CONTACT WORKER: _____

_____ _____
Client's Signature Date

_____ _____
Referral/Alternate Worker's Signature Date

(The alternate contact person is for confirmation or admission process only – the alternate contact will not be included in the release of confidential information prior to, during, or after treatment). The client may change the name of the person to receive the Discharge Summary at any time. It is up to the client to inform their referral worker of the change. ****NOTE: THIS FORM IS APPLICABLE FOR ONE YEAR AFTER THE DATE SIGNED.**



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| MEDICAL ASSESSMENT | |
|---|---|
| **Must be completed by medical personnel (e.g., Physician, Nurse Practitioner, Registered Nurse) Please print clearly.** | |
| Date of Assessment/ Referral: | Are you the applicant's regular Physician/ Nurse? Yes ❑ No ❑ |
| Applicants Name: | Date of Birth: |
| Personal Health Care Number: | Status Number: |

**CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

I, _____ (applicants name), hereby request and authorize _____ (Physician, Nurse Practitioner or Registered Nurse's name) to release medical information pertaining to myself to Kackaamin Family Development Center and to my referral worker acting on my behalf (listed above).

_____ _____
Applicant's Signature Date

_____
Medical Personnel's Position/Title

_____ _____
Physician, Nurse Practitioner or RN's Signature Date

*Informed must be completed with the Patient.*

*****Not: This form is applicable for one year after signed and dated. The Applicant may change or revoke this release at any time by giving notice to the treatment center in writing. *****

Specify any dietary requirements) allergies, intolerances, diabetes, etc.):

| Current Medications (Names) | Dose (ml/ng) | Reason for Taking: | How long has patient been taking? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

1) Have you reviewed client's medications personally? Yes ❑ No ❑
2) Does the applicant take prescribed narcotics or opioid medications? Yes ❑ No ❑



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If yes- what for, what type and how often?

3) Does the applicant take prescribed medical marijuana in any form or oils containing CBD or THC? Yes ❑ No ❑

If yes- what for, what type and how often?

4) Is client taking all medications as prescribed? Yes ❑ No ❑

| **Medical History** | **Comments** |
|---|---|
| Does the applicant have any communicable diseases?<br>Yes ❑ No ❑ | Please Specify: |
| | |
| Does the applicant have any head trauma or cognitive impairment?<br>Yes ❑ No ❑ | Please Specify: |
| Does the applicant have a history of seizures?<br>Yes ❑ No ❑ | Type of Seizures- Please Specify:<br><br>Date of last seizure: |
| Does the applicant have any chronic illnesses or conditions?<br>Yes ❑ No ❑ | Please Specify: |
| Does the applicant have any cardiovascular disorders or conditions?<br>Yes ❑ No ❑ | Please Specify: |
| Does the applicant have any allergies?<br>Yes ❑ No ❑<br>Please Specify: | Does applicant require an Epi-Pen or Ana-Kit?<br>Yes ❑ No ❑<br>*****NOTE- clients are responsible for their own epi-pens and Ana-Kit's- Kackaamin DOES NOT supply***** |
| Is the applicant pregnant?<br>Yes ❑ No ❑ N/A ❑ | If yes, how many weeks. |
| Is client currently receiving specialized medical care? E.g. injections, dialysis, wound care, physio, chiropractor, etc. | Please specify condition being treated and the type and frequency of treatment being accessed. |
| Please provide blood pressure for applicant. | |
| Please provide resting heart rate for applicant. | |



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## Guidance Re: Tuberculosis Screening for Entry into Treatment Centres

**Background:**
Tuberculosis (TB) screening for entry into detox or treatment centres has been a barrier for some clients because of the perceived need to include a Tuberculin Skin Testing (TST) and/or chest x-ray as part of that screening process. Consequently, FNHA TB Services has worked with the FNHA Mental Wellness Clinical Team to simplify the TB screening process by incorporating it directly into the medical assessment part of the treatment centre application. This assessment may be completed by any qualified practitioner (MD, NP, RN).
**The purpose of TB screening for entry into treatment programs is to rule out active TB. Thus, the only requirement for entry into a treatment centre is a negative symptom assessment. A TST or chest x-ray is not required unless the client is having symptoms suggestive of active TB.**
Despite this, **screening for latent TB infection (LTBI) with a TST may be of benefit to the client** since people who use substances are often at higher risk for exposure to TB and at higher risk for progression to TB disease if they have LTBI. Those with known LTBI may also benefit from treatment to prevent active TB disease. As such, we continue to encourage Community Health Nurses to offer screening to these clients as part of their Priority Screening for TB program.

**Process if using the new TB screener contained within the Medical Assessment section of the FNHA Treatment Centre Referral Package**

1. Complete TB screening pages in medical assessment portion of the application.
2. If the client has symptoms suggestive of active TB (productive cough for > 3 weeks, unintentional weight loss, drenching night sweats, etc.), collect 3 sputum for AFB and send client for CXR. Notify FNHA TB services by phone (604-693-6998) or email (FNHATB@fnha.ca) and complete the regular BCCDC TB screening form for submission.
3. If client has no concerning symptoms, complete the remainder of the TB screening part of the medical assessment. Provide education to the clients regarding their individual risks and, if appropriate, the benefit of treating LTBI.
4. Obtain consent from the client to share the information with FNHA TB services.
5. Fax only that section of the medical assessment to FNHA TB Services at 604-689-3302.
6. No additional clearance letter is required.
7. If there is a significant time lapse between when the assessment is done and when the client enters treatment program (i.e. 6 months), advise client to report the development of any symptoms to their health care provider or yourself.
8. If another practitioner is completing the medical assessment you may advise them on this process (e.g. they do not need to refer the client to you for TST).
9. If the client is interested and available at this time for latent TB screening (e.g. TST), or for a discussion regarding the benefits of the treatment of LTBI, you are encouraged to go ahead and do that. Otherwise make arrangements to have the client return at another time for this screening. Add client details to your Priority Screening list to ensure you remember to follow-up.

**Process if using the BCCDC TB Screening Form**
Non-FNHA Treatment Centres may not have incorporated TB screening into their medical assessment package.

1. Complete the BCCDC TB Screening Form as you normally would.
2. If the client has no symptoms of active TB, you can provide clearance for entry (sample clearance letter attached). You do not need to wait to receive a clearance letter from FNHA.
3. No TST or referral for CXR is required unless the client is having symptoms. Check off "TST not done". Provide education to the client regarding their individual risks and, if appropriate, the benefit of treating of LTBI.
4. If the client is available for latent TB screening and a TST is appropriate, go ahead and do that now or have them return at a later date.
5. Fax completed screening form to FNHA TB Services at 604-689-3302 or, if entering into Panorama yourself, notify us that a screening has been done.



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## Guidance Re: Tuberculosis Screening for Entry into Treatment Centres cont…

Documentation in Panorama:
If you have access to Panorama, enter the screening using these steps:

1. Open a TB Investigation (Case - Person Under Investigation)
2. Ensure client demographics are updated, especially the "Address on Reserve Administered By" section. Be sure to mark current address as the "preferred address".
3. In Treatment and Interventions>TB Skin Test Summary, update TB History Summary.
4. Create TB Follow-Up Only (unless skin test is done). Enter 06 as reason for screening if client is going for substance use program or enter 12 if going for trauma/ family program. Under follow-up, select No Follow-Up Required". Under Follow-up Details enter "Client denies signs and symptoms of active TB at present. Cleared for program entry." You can also add other details, such as "Asked client to return next month for TST", etc.
5. Complete the Signs and Symptoms and Risk Factor sections.
6. You may complete allergies and external source information if this is available to you.
7. You can generate a clearance letter directly from Panorama. To do this, ensure you have the Investigation in context. Go to Reporting and Analysis>Reports>Investigations, scroll down to Tuberculosis Disease section. Select the hyperlink RBCY TB005 Client No Active TB Letter. In the top navigation banner, select Generate Report Now. Select Open in Adobe and print for the letter for client.

For additional information or support, please refer to the BCCDC Decision Support Tool or contact FNHA TB Services.

### Section 13: Tuberculosis (TB) Screening

The purpose of TB screening for entry into treatment programs is to **rule out active TB**. *Screening for latent TB is not required, and should never delay program entry*, but might be of benefit to the client and can always be done at a later date.

People who use substances are an important group to consider for regular TB screening and this screening continues to be an essential part of TB prevention and overall wellness.

For follow-up purposes, does client reside in a First Nations community: No Yes (>50% of the time)
Community Name: _____

**TB Symptom Assessment**

| | | |
|---|---|---|
| ☐None | ☐Fever | ☐Short of Breath |
| ☐Chest Pain | ☐Haemoptysis | ☐Sputum Production |
| ☐Cough (for >3weeks) | ☐Lymphadenopathy | ☐Unintentional Weight Loss |
| ☐Fatigure | ☐Drenching Night Sweats | ☐Other: |

*** If client has a cough, or other symptoms consistent with active TB, collect 3 sputum for AFB, send client for CXR, and complete TB Screening Form (Appendix A) for review by TB Services prior to program entry. ***
For clients who live in a First Nations community fax form to FNHA TB Services at 604-689-3302.
For clients who reside within VIHA fax to Island TB Services at 250-519-1505.
For all other clients fax form to BCCDC at 604-707-2690.



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| **TB History** (check all that apply) | |
|---|---|
| ☐ Has the client ever had a positive TST and/ or IGRA result? | |
| ☐Has the client ever been in contact with someone with active TB? | |
| ☐Has the client ever been treated for TB? | |
| If TB history is unclear, please contact FNHA TB Services at 1-844-364-2232. FNHA Clinical Nurse Advisors can provide practitioners with the client's TB history. | |
| **TB Risk Factors** | |
| Certain risk factors pose a higher risk for progression to active TB in the presence of latent TB or increase the risk of exposure to TB (check all that apply): | |
| ☐None | ☐HIV |
| ☐Transplant (specify): | ☐Diabetes |
| ☐Chronic Kidney Disease/Dialysis | ☐Cancer (specify): |
| ☐Substance Use (alcohol or other) | ☐Tobacco Use |
| ☐Immune Suppressing Meds (name, dose, duration): | ☐Homelessness/Underhoused (past or current) |
| ☐Work or live in a congregate setting (past or current) | ☐Work or live in a Correctional Facility (past or current) |
| | |
| If client lives in a First Nations community, please discuss sharing this information with FNHA TB Services for follow-up purposes. | |
| ☐I, _____, consent to sharing the above information with FNHA TB Services.<br>(print name) | |
| Client's Signature: _____ Date: _____ | |
| Client's Date of Birth:_____ | |
| If consent provided, please fax this page to FNHA TB Services at 604-689-3302. | |



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ANY ADDITIONAL COMMENTS OR CONCERNS:

| |
|---|
| |

***Please return completed medical to:***

Julie Fontaine
Intake Coordinator
Kackaamin Family Development Center
PH: 250-723-7789 FAX: 250-723-5926
Email: julie.f@kackaamin.org



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# Adult Intake Application

## Counselling Involvement and Summary

***To be completed by current counsellor, and returned to intake coordinator.***

| **Counselor Information** | | |
|---|---|---|
| Date of Form Completion: | Counselor's Name: | Title/Position: |
| Organization/Agency Name: | Email: | Fax: |
| Address: | City, Province Postal Code | |
| **Client Information** | | |
| Client name: | | |
| Does the applicant have a post-treatment appointment set? ☐ Yes ☐ No<br>If yes, date: _____ | | |
| Has the applicant completed pre-treatment sessions? ☐ Yes ☐ No | | |
| Please provide all counselling session dates in the last 3 months: | | |
| Clients Presenting Problem? | | |
| Summary of Issues Being Addressed in Sessions: (please use additional paper and attach to this form if needed): | | |

**Please return to:**

Julie Fontaine
Intake Coordinator
Kackaamin Family Development Center
PH: 250-723-7789
Fax: 250-723-5926



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