AUTHORIZATION TO RELEASE INFORMATION 9

(Parent or guardian should complete this page)

I _____ do hereby authorize Leading
(Print Name of Parent/Guardian)

Thunderbird Lodge Youth Treatment Center to obtain information about my child.

_____ From Court Workers, Parole or Probation
(Name of Youth)

Officers, Social Workers, Medical or Psychiatric Practitioners, Educators or other relevant Professionals.

This consent is given from the date of signing and until 6 months from discharge or completion of the program. I am also consenting for Leading Thunderbird Lodge to release such information, only as necessary, to other agencies, when required by law.

Parent/Guardian Signature: _____

Date: _____
Month/Day/Year

(This authorization expires 6 months from the date above)

Witness: _____

Please fill out all form's completely failure to do will result in delay with acceptance

YSAC

Youth Services Intake Form

This form is to be completed in full when applying to have a client admitted to one of the National youth inhalant treatment centers.

Centre applying to: _____

Client Information: New intake date_____ Repeat Intake date_____

How did you hear of LTL: _____

Name: _____

Date of Birth: _____ (d/m/y) Age at present _____ Male: ☐ Female: ☐

Medical Number: _____Province of Registration_____ Expiry Date_____

Band Name and Number (10 Digits): _____

Social Insurance Number: (If Available) _____

Treaty Number: _____

Client Address: _____

Languages: Spoken English _____ Other: _____ Understood English _____ Other: _____

Referral Information

Social Services Involvement:

Agency Name: _____

Phone No.: _____

Please fill out all form's completely failure to do will result in delay with acceptance

Worker Name: _____

Client Status: Crown Ward ____, Society Ward ____, Voluntary Placement ____, Customary Care ____

VPA ____\ other: _____

Family History:

Biological Parents: _____

Guardian: _____

Address: _____

_____

Phone No.: _____

Place of Employment: _____

Phone No.: _____

(Please list all who are considered siblings by the client, including customary, step and foster siblings)

Name	Age	Health Status	Lives With

Please fill out all form's completely failure to do will result in delay with acceptance

Extended Family:

Maternal: _____

Paternal: _____

Languages: (spoken predominantly, other) _____

Religious Beliefs: Traditional ☐ Roman Catholic ☐ Protestant ☐

Other: _____

Education:

1. Does your client go to school? Yes ☐ No ☐
2. Does your client like school? _____
3. Highest grade completed? _____
4. Name of school and last year attending this school _____

Relationships:

5. Does client live with: Mom ☐ Dad ☐ Alone ☐
   Extended Family Members ☐ Siblings ☐ Friends ☐
6. How does your client get along with his family members? _____
7. Who does your client feel closest to? _____
8. Does he have any close friends? If so who? _____
9. Does he talk to any elders? Is he willing to listen? _____
10. Does he have a girlfriend or boyfriend? _____

Please fill out all form's completely failure to do will result in delay with acceptance

11. Is he sexually active? _____

12. Family Support:_____

13. Family Strenghts:_____

Medical History:

14. Does your client have any medical problems? (please identify) _____

15. Has he ever received a diagnosis? (Cognitive Disability/Mental Health)

_____

16. Does he require a medical consent form? _____

17. Family doctor's name and telephone number: _____

18. Is your client currently on any medication? _____

19. Does he have any allergies? _____

Legal Problems:

20. Has your client ever been in trouble with the law? _____

If yes please send all court documents otherwise intake will be delayed

21. Was alcohol or any other substances, such as "sniff" or drugs involved during your client's legal problems? _____

22. Is your client currently on probation or on a court order? Yes ☐ No ☐

Name of probation officer: _____

Please fill out all form's completely failure to do will result in delay with acceptance

Phone No.: _____

FAX No.: _____

Probation Order: From _____ TO _____

Conditions: _____

Copy Attached? **Yes** ☐ **No** ☐

Solvents/Substance Abuse:

Chemical Use History:

23. At what age did your client start **sniffing**? _____

24. At what age did your client start **alcohol**? _____

25. At what age did your client start **using other drugs**? _____

26. Has your client ever used any of the following:_____

Substance	Yes	No	How long? (months/years)
Gasoline			
Glue			
Cigarettes			
Spray Paint			
Rubber Cement			
Nail Polish Remover			
Hard Liquor			

Please fill out all form's completely failure to do will result in delay with acceptance

Marijuana			
Fabric Protector			
Crack			
Beer			
Other _____			
Other _____			

27. Does anyone else in his family use solvents/substances? Yes ☐ No ☐

28. If so, who else? _____

29. What solvents/substances are mainly used? _____

30. Does he use solvents/substances with others or by him self _____

31. Where does your client usually sniff or huff?

Place	Yes	No	Last date used	Place	Yes	No	Last date used
At home				Abandoned Car /Truck			
A Friend's House				At a Party			
School				Outdoors			
Abandoned Building				Other			

32. Has your client ever lost friends because of sniffing or huffing? Yes ☐ No ☐

33. Has your client ever gotten into any physical fights when using? Yes ☐ No ☐

34. Has your client ever caused serious injury to other? Yes ☐ No ☐

Please fill out all form's completely failure to do will result in delay with acceptance

Please explain.

_____

35. Does he have any medical, physical, psychological, emotional problems because of the use of solvents/substances? Yes ☐ No ☐

Explain:

_____

36. Does he feel that they have control over their use of solvents/substances? Yes ☐ No ☐

37. Has he ever considered reducing or quitting? Yes ☐ No ☐

38. Has he ever been in any previous treatment for their use of solvents/substances? Yes ☐ No ☐

Where _____When_____

39. How long did the client stay in the program? _____

Psychological Functioning

40. Has your client ever spoken or wrote about killing himself? Yes ☐ No ☐

41. Has your client ever attempted to kill himself? Yes ☐ No ☐

42. How many times? Dates? _____

43. How did he attempt to kill himself? _____

44. Has the client frequently gone off on their own when he is depressed (unhappy)? Yes ☐ No ☐

45. Is the client sad/unhappy? Yes ☐ No ☐

Please fill out all form's completely failure to do will result in delay with acceptance

None of the time ☐ some of the time ☐ Most of the time ☐ All of the time ☐

46. Is there any known history of sexual abuse? Yes ☐ No ☐

47. Is there any known history of physical abuse? Yes ☐ No ☐

48. Is there any known history of emotional abuse? Yes ☐ No ☐

49. Please explain (i.e. at what age? Has it been reported and what is the outcome or current status)?

---

50. Has your client had any involvement with gangs?

Please Explain: _____

Trauma

51. Is there any history of family violence that this child may have been witness to? Yes ☐ No ☐

Please Explain: _____

52. Is there any known history of other forms of traumatic experience? (Including complex grief, bullying)

Yes ☐ No ☐

Please Explain: _____

When the client is in a sober state:

53. Has he communicated with spirits that no one else can see or hear? Yes ☐ No ☐

54. Has this happened? Never ☐ Sometimes ☐ Most of the Time ☐

Please fill out all form's completely failure to do will result in delay with acceptance

55. Are these positive or negative experiences for the client? Please explain. _____

56. Are there times when people are unable to communicate with the client?

Not at all ☐ Sometimes ☐ Most of the time ☐ All of the time ☐

Please explain: _____

57. Has your client ever had any psychological testing or counseling? Yes ☐ No ☐

For what purpose?

_____

Outside Resources:

58. Are there any other agencies involved with your client and his family? Yes ☐ No ☐

59. If so, which ones and what services do they provide? (For example, NNADAP, CHR, CFS)

_____

Family:

60. Family Activities/Practices: (What do you see as a family?)

_____

61. Family Roles/Relationships: (How do they interact with each other?) _____

_____

62. Status in the Community: (How is the family perceived in the community?)

_____

Please fill out all form's completely failure to do will result in delay with acceptance

63. What type of belief system is practiced? _____

64. How does he spend his leisure time? _____

65. Who is the other support people involved with the family? (Example, elders, extended family, community groups, community workers, CHR, NNADAP, CWPW)

_____

_____

66. Is the client/family aware of the effects of solvents/substances?

Client:	Yes ☐	No ☐
Family:	Yes ☐	No ☐
Community Worker:	Yes ☐	No ☐

67. Does the family believe the client recognizes that he has a problem? What steps does the family want to take to address the problem?

_____

_____

68. Has anyone in his family or community received treatment for solvent/substance abuse?

_____

69. Are the parent(s) supportive of their child receiving treatment? (Refer to referral agent agreement and parental consent form) _____

Please fill out all form's completely failure to do will result in delay with acceptance

70. Upon the child's completion of the program, what type of support system do you see as effective/useful to help maintain a clean lifestyle for self/child?

_____

71. Are the extended family members supportive of the family seeking help and/or treatment for themselves or their child?

_____

72. Would the family be willing to come to our Treatment Centre to observe the program in action as part of the intake process? _____

73. Significant losses or areas that may be affecting the child related to unresolved grief

---

What are your expectations of this program: _____

_____

Workers Recommendations:

Indicate what areas of healing he feels that we should concentrate on? _____

_____

_____

Any additional information that your client or family feels that might contribute to his treatment?

_____

Please fill out all form's completely failure to do will result in delay with acceptance

Please send any previous placement / group home assessment and any relevant information

Name of the Adult who filled out the intake with the youth_____

Email of client for aftercare follow up_____

Clients Email for aftercare follow up_____

Please list any cognitive delays or any concerns you would like us to be aware of:

_____

_____

Please forward this information to the treatment center at your earliest convenience

Centre Name

Mailing Address

Phone

Fax

Contact Person

Please fill out all form's completely failure to do will result in delay with acceptance

EXTRA CURRICULAR ACTIVITIES CONSENT FORM 1

During the four months of care, extra-curricular activities will be provided. Staff will always be in attendance and safety will be predominant during our outings. This is to provide consent for outdoor activities such as:

- **Cultural Program:**
  Sweats/Smudging/Medicine Walks/Teepee Teachings/Hide Tanning/Drum making/Picking Rocks/Gathering Wood, etc

- **Winter Activities:**
  Skating/ Ice Fishing/ Hockey/ Sledding

- **Summer Activities:**
  Swimming/Boating/Fishing/Hiking/Biking/Canoeing/Sports, etc.

- **Horse Program:**
  Class instructions/Outdoor hands on instructions

- **Other:**
  Camping/Outdoor Volleyball/Baseball/Archery/Wiener Roasts, etc.

I _____ give my consent for _____
(Parent/Guardian) (Youth)

To attend activities that are identified above or provided during the course of their treatment.

Parent/Guardian Signature _____

Dated _____

Please fill out all form's completely failure to do will result in delay with acceptance

MEDICATION ADMINISTRATION CONSENT 2

Client:

_____

PRN Medication

I, _____ guardian of
_____ give authorization to staff at Leading Thunderbird Lodge to administer the following non-prescription drugs:

_____

_____

At the request of/or when deemed in the best interest of,
(Client's
Name)_____

PRESCRIPTION Medication

I, _____guardian of _____
give authorization to staff at Leading Thunderbird Lodge to administer any medications in strict accordance with specified directions and as prescribed by a physician.

Allergies

Please note if the client has any allergies to a specific type of medication:

_____

Self-Administration of PRESCRIPTION Medication

I, _____ guardian of
_____ give authorization to
_____ (client name) to self-administer prescribed medications in strict accordance with specified directions and as prescribed by a physician. The client will be aware of reasons for taking medication; correct administration; potential adverse effects and what to do in an emergency situation.

_____ _____

Name of Parent/Guardian (please print) Signature of Parent/Guardian

Date_____

Please fill out all form's completely failure to do will result in delay with acceptance

PARENTAL/GUARDIAN CONSENT TO TREATMENT 3

I/We, the parent(s)/ legal guardian(s) of _____do hereby agree and consent to have the above named admitted to residential treatment at Leading Thunderbird Lodge, Fort Qu'Appelle, Saskatchewan.

Intake date: _____

Discharge date: _____

(Please Print)

Parent/Guardian Name(s):

_____

Parent/Guardian Signature(s):

_____

Date: _____

Witness: _____

YOUTH CONSENT

If I am accepted to Leading Thunderbird Lodge Treatment Center I understand that I will be expected to sign a "Treatment Agreement" within the first 48 hours. If I choose not to sign I may be released/discharged at the earliest convenience. I understand that arranging for an early discharge will be my referral workers responsibility although Leading Thunderbird Lodge will ensure that safe and adequate arrangements have been completed where possible.

(Please Print)

Youth Name: _____

Signature: _____

Date: _____

Witness: _____

Please fill out all form's completely failure to do will result in delay with acceptance

Parent/Guardian/Client/ Permission of Client Images/Client Work 4

It is agreed that Leading Thunderbird Lodge may display photo images

and the work of my child _____

with or without my child's name.

This consent shall remain in effect as the client is in attendance at Leading Thunderbird Lodge.

If situations arise that causes you, as a parent/guardian to be concerned about your child's privacy, please contact Leading Thunderbird Lodge in writing to make changes to your permission.

If this form is not returned to Leading Thunderbird Lodge it is assumed Consent is given, unless otherwise advised.

_____ _____

Parent/Guardian Name (Print) **Parent/Guardian Signature**

_____ _____

Client Name (Print) **Client Signature**

_____ _____

LTL Staff Name (Print) **LTL Staff Signature**

_____

Date

Please fill out all form's completely failure to do will result in delay with acceptance

OUT OF PROVINCE CONSENT FORM 5

Leading Thunderbird Lodge is planning a trip to: (describe trip, location dates, and description of activities/event/program schedule)

Because this is an out of province trip we require parental/guardian consent for Leading Thunderbird Lodge and accompanying counselors/ chaperones:

Staff Names and Titles:

_____

_____

To take your youth out of province. They will be departing on _____and returning on_____

I _____, do give my consent for _____
(Parent/Guardian-Print) (Youth Name)

To attend the out of province trip mentioned above, under the supervision of Leading Thunderbird Lodge Staff.

_____, _____
Parent(s) /Guardian (signature)

Daytime phone # (_____) _____ Cell Phone# (_____) _____

Dated: _____

Please fill out all form's completely failure to do will result in delay with acceptance

This Form MUST Be Completed By
A Medical Professional ONLY

MEDICAL EXAMINATION 6

CLIENT NAME: _____

1. List any known drug(s) used: _____

2. Any recent history of: (check)

Scabies	____ Yes	____ No
STD's	____ Yes	____ No
Lice	____ Yes	____ No

3. Any psychiatric- suicidal ideation and /or attempts, clinical depression, other?
(***IF YES PLEASE COMMENT ON #13.)*** YES ____ NO ____

4. Any history of seizures? YES ____ NO ____
If yes, please elaborate: _____
_____

5. Any allergies? YES ____ NO ____
If yes, please list:
_____
_____

6. List visible marks and tattoos: _____
_____

7. Any dietary restrictions? YES ____ NO ____
If yes please list: _____
_____

8. Has a Tuberculosis Screening Test been done for this client? YES ____ NO ____
(IF NO PLEASE ENSURE IT'S COMPLETED)
Date of Test: _____
Results: **Negative** ____ **Positive** ____
Chest X-Ray: YES ____ NO ____
Interpretation: _____
Prophylaxis: _____ Date Started: _____

9. Has this client had any or all Hepatitis B immunizations? YES ____ NO ____
If yes, how many? _____ Next due: _____

Name of Doctor or Nurse Administering Test: _____
Address of Clinic: _____

Please fill out all form's completely failure to do will result in delay with acceptance

CLIENT NAME _____

10. FUNCTIONAL INQUIRY

Specify

	NORMAL	ABNORMAL
Gastrointestinal	_____	_____
Genito-Urinary	_____	_____
Respiratory	_____	_____
Cardiac	_____	_____
Musculoskeletal	_____	_____
Hair/Skin/Nails	_____	_____
Blood/Lymphatic	_____	_____
Ear/Nose/Throat	_____	_____

11. PHYSICAL EXAMINATION:

	NORMAL	ABNORMAL
Appearance	_____	_____
Ear/Nose/Throat	_____	_____
Hair/Skin/Nails	_____	_____
Reticuloendothelial	_____	_____
Musculoskeletal	_____	_____
Cardiovascular	_____	_____
Respiratory	_____	_____
CNS	_____	_____
Abdomen	_____	_____
Thyroid	_____	_____
Genito-Urinary	_____	_____

12. Height: _____ Weight: _____

13. Please comment on any abnormalities in the functional inquiry or the physical examination:

_____

_____

_____

_____

_____

Please fill out all form's completely failure to do will result in delay with acceptance

CLIENT NAME: _____

14. Any problems prior to treatment that require follow-up? Please describe:

_____

_____

_____

15. Do you have any comments, suggestions or insights that might be helpful in terms of the client being physically(moderate physical exercise) and mentally able to participate in group and/or one on one counseling (i.e. Hearing problems) and living in residence for the duration of the program? _____

_____

_____

_____

16. If any prescribed medications are required during treatment please list and briefly describe instructions for the client: _____

_____

_____

I have examined this client and find him to be: FIT _____ NOT FIT _____ to attend Treatment.

_____ _____

Physicians Signature **Date**

_____

Physicians Name (PRINT)

Office/Clinic Address: _____

_____

_____

Office Phone #: _____

Please fill out all form's completely failure to do will result in delay with acceptance

YOUTH DIETARY ALERT FORM 7

Name: _____

Date: _____

Describe or select the Special Dietary condition which restricts the Youth's diet and/or likes/dislikes of certain foods.

_____

_____

_____

(Please check applicable information, fill in blanks)
____ Lactose Intolerance - [NO MILK] _____

_____

____ Food Intolerance: _____

____ Food Allergy: _____

____ Food Likes: _____

Food Dislikes: _____

Parent/Guardian Signature: _____

Please fill out all form's completely failure to do will result in delay with acceptance

Youth Telephone # Call Sheet 8

Parent/Guardian/Referral Worker Contact Numbers:

Youth Name: _____

Parent/Guardian: _____

Referral Worker: _____

Emergency Contact: _____

Intake Date: _____

(LIST of approved safe parent/siblings/significant others/workers phone #'s)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

TREATMENT READINESS INVENTORY

INSTRUCTIONS: Read each statement then mark in the box whether you AGREE or DISAGREE with the statement as it applies to your use of, Alcohol, Marijuana, other non-prescribed drugs. Mark each statement truthfully. There is no right or wrong answer.

Do not make any guesses, MARK EACH STATEMENT ONLY ONCE, BUT BE SURE TO MARK EVERY STATEMENT

AGREE	DISAGREE	
☐	☐	1. I do not have a problem with drinking/drug use.
☐	☐	2. I know I drink/use too much.
☐	☐	3. I will quit drinking/using only when I am good and ready.
☐	☐	4. I do have a problem with drinking/using
☐	☐	5. I must quit drinking/using once and for all.
☐	☐	6. People talk about my drinking/using.
☐	☐	7. I have my drinking/using under control.
☐	☐	8. People can help with my drinking/using problems.
☐	☐	9. I do not want anyone telling me what to do about my drinking/using.
☐	☐	10. I can quit drinking/using whenever I want
☐	☐	11. I need help now for my drinking/using problems.
☐	☐	12. My family worries about my drinking/using.

AGREE	DISAGREE	
☐	☐	13. I do not care who knows I am getting help for my problems with drinking/using
☐	☐	14. People have good reason to talk about my drinking/using.
☐	☐	15. My drinking/using causes problems in my life.
☐	☐	16. No one is going to force me to quit drinking/using.
☐	☐	17. I need to talk honestly with other people about my drinking/using.
☐	☐	18. People have no reason to talk about my drinking/using.
☐	☐	19. I do not care who knows I am getting help for my problems with drinking/using.
☐	☐	20. There are times I had to cut down my drinking/using
☐	☐	21. I cannot control my drinking/using any more.
☐	☐	22. There is no need for me to stop drinking/using.
☐	☐	23. I am going to stop my drinking/using no matter what it takes.
☐	☐	24. I must do something about my drinking/using problems now, or they will only get worse.
☐	☐	25. What I do about my drinking/using is nobody's business.

PLEASE MAKE SURE YOU HAVE MARKED EVERY STATEMENT ONLY ONCE