LEADING THUNDERBIRD LODGE
YOUTH TREATMENT CENTER

Leading Thunderbird Lodge is a residential youth treatment center located in the beautiful and scenic Qu'Appelle Valley 5 minutes outside of Fort Qu'Appelle Saskatchewan in the Village of Fort San. Leading Thunderbird Lodge is designed to meet the needs of First Nations & Inuit male youth between the ages of 12-17 years old who are experiencing difficulties related to drug, alcohol and solvent abuse. The program is based on a holistic treatment model, and the four areas of the Medicine Wheel: Mental, Social, Physical and Spiritual needs will be addressed

Questions:

- Are you wanting a better life?
- Do you feel like no one understands you?
- Do you wish you could quit drinking?
- Do you wish you could quit doing drugs?
- Do you wish you could quit sniffing?

If you answered yes to any of the questions above and are willing to make changes in your life, then please refer to our website to download an intake package or call our office and ask for the intake worker.
(If the intake worker is unavailable, please ask the front desk to fax you the intake package)
OUR OUTREACH DEPARTMENT ALSO OFFERS INFORMATIONAL PRESENTATIONS ON DRUGS, ALCOHOL AND SOLVENT ABUSE TOPICS

CONTACT INFORMATION
PHONE (306) 332 5659 FAX (306) 332 1850
EMAIL: leadingthunderbirdlodge@sasktel.net
Web: www.leadingthunderbirdlodge.ca

Leading Thunderbird Lodge
555 Fort San Road
PO Box 400
Fort Qu'Appelle, SK S0G 1S0
Toll Free: 1-866-494-4815
Phone: 306-332-5659 Fax: 306-332-1850
Email: leadingthunderbirdlodge@sasktel.net

WHO ARE WE AND WHERE WE ARE LOCATED:

Leading Thunderbird Lodge is a residential treatment facility that offers a three (3) month treatment program for male youth between the ages of 12-17 who are experiencing addictions/challenges with alcohol, drugs or solvents. The Lodge is located five minutes outside of Fort Qu'Appelle, Saskatchewan.

WHAT OUR PROGRAM IS ABOUT AND OFFERS:

The in-patient residential treatment program at Leading Thunderbird Lodge is based on a holistic treatment program that offers personal growth and development in the areas of mental, social, physical and spiritual well-being. Our program is unique, as we offer a culturally based program with First Nations cultural teachings offered through programming facilitated by in-house or invited Elders.
The Lodge has a maximum capacity of 15 residential beds, a full-size gymnasium, a fully equipped weight room, a spiritual room, classroom and is staffed 24/7 by trained, certified and caring personnel.

HOW TO APPLY OR REFER A YOUTH:

The first step in the application process is to complete and send in an Intake Package. To obtain a copy of this package, you can either call our office or request a fax copy or an email copy.
Website: www.leadingthunderbirdlodge.ca to print off the forms.

INSTRUCTIONS FOR COMPLETING THE INTAKE PACKAGE:

- Please read the entire package carefully prior to completing it
- Please write legibly
- Please complete all questions, if an answer is "unknown" please state why it is unknown"
    - Do not leave any question blank
- ALL forms MUST be completed and received by Leading Thunderbird Lodge for the applicant to be considered for acceptance.
- If our occupancy is full, the applicant will be placed on the Wait List and will be contacted when a space becomes available.

ADDITIONAL NOTE FOR APPLICANT:

The applicant must VOLUNTARILY want to attend the program – this will aid them in their success in the program and as this is not a secure facility, should a youth want to leave, they can do so (unless under court/legal order).
Youth who may be a high risk to themselves or others will not be accepted.
CONTACT INFORMATION: If you have any questions about the application process or the program we offer, please contact our Intake/Outreach worker who will be happy to assist you.

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TREATMENT READINESS INVENTORY

INSTRUCTIONS: Read each statement then mark in the box whether you **AGREE** or **DISAGREE** with the statement as it applies to you personally at this time. Mark each statement truthfully. There is no right or wrong answer.

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.
☐	☐	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.
☐	☐	13. I do not care who knows I am getting help for my problems with drinking/using.
☐	☐	14. People have a 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 drink/use.
☐	☐	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 is nobody's business.

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YSAC
Youth Services Intake Form

This form is to be <u>completed in full</u> when applying to have a client admitted to one of the National Youth Inhalant Treatment Centres. Any blank areas may be considered incomplete.

Centre applying to: _____

Client Information: New intake date_____ Repeat Intake date_____

How did you hear of Leading Thunderbird Lodge (LTL)?

_____

<u>Referral Information</u>

Name:_____

Date of Birth: _____ (**dd/mm/yy**) Age at present _____

Male: ☐ **non-Binary**: ☐

Health Card Number: _____**Province of Registration**_____

Expiry Date_____

Band Name and Number :_____

Treaty Number (10 Digits): _____

Social Insurance Number: (If Available) _____

Client Address: _____

Languages: Spoken English____ Other: _____ Understood English ____

Other: _____

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Referral Agent & Agency:

Social Services Involvement:

Agency Name: _____

Phone Number:_____ Fax Number: _____

Worker Name: _____

Worker Title: _____

Worker Email: _____

Child Welfare Involvement:_____

Client Status: Crown Ward ___, Society Ward ___, Voluntary Placement ___,

Customary Care ___VPA ___\ other: ____

Family History:

Biological Parents: _____

Who does the Client currently live with? _____

Guardian: _____

Address: _____

Phone Number:_____

Place of Employment: _____

Work Phone Number: _____

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

Name	Age	Health Status	Lives With

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 _____
5. If answered No to client not in school, please explain why?

   _____

Relationships:

6. Does client live with: Mom ☐ Dad ☐ Alone ☐ Extended Family Members ☐
   Siblings ☐ Friends ☐
7. How does your client get along with his family members? _____

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8. Who does your client feel closest to? _____

9. Does he have any close friends? If so, who? _____

10. Does he talk to any elders? Is he willing to listen? _____

11. Is the client currently in a relationship? _____

12. Is he sexually active? _____

Does he have any children? _____

13. Family Support:_____

14. Family Strengths:_____

Medical History:

15. Does your client have any medical problems? (Please identify) _____

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

17. Does he require a medical consent form? _____

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

19. Is your client currently on any medication? _____

20. Does he have any allergies? _____

Legal Problems:

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

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

22. Has your client had any involvement with

gangs?_____

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

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Name of probation officer: _____

Phone No.: _____

FAX No.: _____

Probation Order: From _____TO _____

Conditions: _____

Copy Attached? **Yes** ☐ **No** ☐

Solvents/Substance Abuse:

Chemical Use History:

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

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

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

27. 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	☐	☐	
Marijuana	☐	☐	
Fabric Protector	☐	☐	
Crack	☐	☐	

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Beer	☐	☐	
Other _____	☐	☐	

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

29. If so, who else? _____

30. What solvents/substances are mainly used? _____

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

32. 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	☐	☐	

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

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

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

Please explain. _____

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

Explain: _____

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

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

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

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Where _____When_____

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

Psychological Functioning

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

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

43. How many times? Dates? _____

44. How did he attempt to kill himself? _____

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

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

None of the time ☐ Some of the time ☐ Most of the time ☐ All of the time ☐

Self-harming behaviors: Yes ☐ No ☐ unknown ☐

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

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

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

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

_____

_____

Trauma

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

Please Explain: _____

51. 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:

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

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

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

55. 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: _____

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

For what purpose? _____

Outside Resources:

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

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

_____

Family:

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

_____

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

_____

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

_____

62. What type of belief system is practiced? _____

63. How does he spend his leisure time? _____

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

_____

_____

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

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

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

_____

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

_____

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

69. 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?_____

_____

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

_____

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

72. Has there been significant losses or areas that may be affecting the child related to unresolved grief?

_____

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73. What are your expectations of this program? _____

_____

Worker 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 send any previous placement/group home assessments and any other relevant information.

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

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

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EXTRA CURRICULAR ACTIVITIES CONSENT FORM 1

During the three months of care, extra-curricular activities will be provided. Staff will always be in attendance and safety will be predominant during 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 _____ (Parent/Legal Guardian) give my consent for _____(Youth name)

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

Parent/Legal Guardian Signature _____

Dated _____

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MEDICATION ADMINISTRATION CONSENT 2

Client Name: _____

PRN Medication

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

_____

PRESCRIPTION Medication

I, _____ (parent/legal 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, _____ (parent/legal 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/Legal Guardian (please print) Signature of Parent/Legal Guardian

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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:_____

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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

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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 _____, (Parent/Legal Guardian) do give my consent for_____
_____ (Youth Name)
To attend the out of province trip mentioned above, under the supervision of Leading Thunderbird Lodge Staff.

_____
Parent(s)/Legal Guardian (signature)

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

Date: _____

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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 WITHIN THE PAST 3 MONTHS)

Date of Test: _____

Results: Negative ___ Positive ___

Chest X-Ray: Yes ☐ No ☐

Interpretation: _____

Prophylaxis: _____ Date Started: _____

9. Has a **COVID 19** Screening Test been done for this client? Yes ☐ No ☐
(IF NO PLEASE ENSURE IT'S COMPLETED WITHIN 7 Days of Intake Date, provide documentation and proof)
Date of Test: _____ **Results: Negative ___ Positive ___**

If positive, does Client need to self-isolate? Yes ☐ No ☐

How long? _____

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10. Has youth received the Covid 19 Vaccination? Yes ☐ No ☐
(If Yes, Please indicate which Vaccine along with proof of vaccination)
_____

11. 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: _____

12. FUNCTIONAL INQUIRY
Specify

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

13. PHYSICAL EXAMINATION:

	NORMAL	ABNORMAL
Appearance	☐	☐
Ear/Nose/Throat	☐	☐
Reticuloendothelial	☐	☐
Musculoskeletal	☐	☐
Cardiovascular	☐	☐
Respiratory	☐	☐
CNS	☐	☐
Abdomen	☐	☐
Thyroid	☐	☐
Genito Urinary	☐	☐

14. Height: _____ Weight: _____

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

_____

_____

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PO Box 400
Fort Qu'Appelle, SK S0G 1S0
Toll Free: 1-866-494-4815
Phone: 306-332-5659 Fax: 306-332-1850
Email: leadingthunderbirdlodge@sasktel.net

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

_____

_____

17. 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?

_____

_____

_____

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

_____

_____

_____ _____

Physicians Signature **Physicians Name (Print)**

Date _____

Office/Clinic Address: _____

_____

_____

Office Phone:_____

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

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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(s): _____

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Youth Telephone Number Call Sheet 8

Youth Name:_____

Parent/Legal 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. _____

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AUTHORIZATION TO RELEASE INFORMATION (Form 9)

(Parent or Legal Guardian should complete this page)

I _____ **(Print Name of Parent/Legal Guardian)** do hereby authorize Leading Thunderbird Lodge Youth Treatment Center to obtain information about my child.

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

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10/TOBACCO OFFERING CONSENT

Leading Thunderbird Lodge requires your permission with your written consent for your youth to participate in the harm reduction program as part of their healing process. Youth will be permitted 2 tobacco offerings per day, at designated breaks, while they are in treatment.

I _____ **DO NOT** give my consent to allow
(Parent/Guardian)

_____ to accept tobacco offerings.
(Youth)

OR

I _____ **DO** give my consent to allow
(Parent/Guardian)

_____ to accept tobacco offerings.
(Youth)

Parent/Guardian Signature: _____

Youth Signature: _____

Date:_____

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