Nightwind Treatment Centre
Miyokiw (grow well)
www.nightwind.ca
(780) 983-1874
info@nightwind.ca

Admission Package

Section 1: REFERRAL AGENT INFORMATION		
Referral Date:		
Referral Agent Name:	Position:	
Organization:		
P.O. Box/Address:	Town/City:	
Province:	Postal:	Email:
Telephone:	Fax:	Cell phone (optional):
Supervisor Name:		
Email:	Telephone:	

Please select which program you are applying for admission: (You may select more than one)

☐ Kihew House, Sturgeon County	☐ Thunderbird Landing, Tawatinaw Valley	☐ Grandmother Turtle House, Westlock
• 9-bed, Rural Treatment Program for young women ages 12-18 • Treatment program supporting abuse history, substance abuse, conflict • Trauma-informed care integrated into the program • Indigenous cultural teachings and experiences as the foundation of treatment aligned with the medicine wheel and seven sacred teachings.	• 7-bed, Rural Co-Ed Receiving and Treatment Program for youth ages 12-18 • Receiving program for youth in preparation for treatment and early treatment support • Trauma-informed care integrated into the program • Healing and skill-building through agricultural programming and cultural teaching.	• 4-bed, Small Town TSIL Program for young women 15-22 • Transition to Semi-Independent Living program • Trauma-informed care integrated into the program • Focus on daily living skills, school success, employment and transitioning to independence. • Please note youth new to NWTC require youth to stabilize at least 4 weeks at Kihew or Thunderbird Landing.

Section 2: PARENT & GUARDIAN INFORMATION		
Mother's Name:	Father's Name:	
Home Address:	Community:	
P.O. Box/Address:	Town/City:	
Province:	Postal:	Email:
Telephone:	Fax:	Cell phone (optional):

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Legal Guardian Name:		
Relationship to youth:	(Bio/adoptive parent/child welfare authority)	
Length and time as Guardian:		
P.O. Box/Address:	Town/City:	
Province:	Postal:	Email:
Telephone:	Fax:	Cell phone (optional):

Section 3: YOUTH INFORMATION

Surname:	First Name:	Middle Name:
Date of Birth(mm/dd/yy):	Current Age:	
Sexual Gender:	Identified Gender:	
Health Care No (6 digit):	Band No. (Treaty):	

Please provide history of CPS issues / involvement

Does the youth have any criminal history or outstanding charges? □Yes □No

If yes, please describe.

Does the youth have any sexual abuse/deviancy issues? Abused or Abuser? □Yes □No
If yes, please describe:

How does the youth/child feel about this placement? How do the parents/caregivers feel about the placement?

Is there any history of the youth being violent/aggressive? (youth/adults/staff/authority) □Yes □No
If yes, please describe:

What some of the youth's strengths?

What some interests that this youth has?

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What are some of the positive things this youth uses to manage stress?
What are the short- and long-term goals for this youth?

Section 3: MEDICATION INFORMATION

List any formal medical diagnosis:	
Date of last visit to Dentist:	
Dentist Name:	Dentist Contact:
Date of last visit to Optometrist:	
Optometrist Name:	Optometrist Contact:
Date of last Medical visit:	
Current Medical Doctor Name:	Medical Contact:
Date of last Psychiatrist visit:	
Current Psychiatrist Name:	Psychiatrist contact:

Name of Current Medication	Medication dosage	How long	Reason for Medication:

When was the last time their medication was reviewed?
Are all immunizations for the youth up to date? ☐Yes ☐No ☐Unsure
Is this youth waiting on a specialist appointment? ☐Yes ☐No If yes, please describe:

Current Medical Doctor Name:	Medical Clinic Name:
Medical Doctor contact information:	

Does the youth have any allergies? ☐Yes ☐No If yes, please describe:

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Is there a current psychologist, psychiatrist and/or other mental health professional engaged with this youth? ☐Yes ☐No If yes, please describe:
Other serious illness history:
Does the youth have a history of suicide attempts? ☐Yes ☐No If yes, please describe history:

Substance Abuse Experience: Has the youth tried any of the following?	If yes, please describe.
Huffing solvent/gas ☐Yes ☐No ☐Suspected	
Marijuana ☐Yes ☐No ☐Suspected	
Alcohol ☐Yes ☐No ☐Suspected	
Cocaine ☐Yes ☐No ☐Suspected	
Crack ☐Yes ☐No ☐Suspected	
Ecstasy ☐Yes ☐No ☐Suspected	
Crystal Meth ☐Yes ☐No ☐Suspected	
Other ☐Yes ☐No ☐Suspected	
Has the youth been admitted to alcohol or substance treatment before? ☐Yes ☐No	
Health Concerns: Does the youth have any of the following health concerns?	If yes, please describe.
Eating Disorder ☐Yes ☐No ☐Suspected	
Seizures ☐Yes ☐No ☐Suspected	
Head Injury ☐Yes ☐No ☐Suspected	
Infectious disease ☐Yes ☐No ☐Suspected	
Hepatitis ☐Yes ☐No ☐Suspected	
Diabetes ☐Yes ☐No ☐Suspected	
Heart Condition ☐Yes ☐No ☐Suspected	
Gastrointestinal Condition ☐Yes ☐No ☐Suspected	
Bed wetting ☐Yes ☐No ☐Suspected	
Sexually Transmitted Infection(s) ☐Yes ☐No ☐Suspected	
Physical Disability ☐Yes ☐No ☐Suspected	
Respiratory Conditions ☐Yes ☐No ☐Suspected	
Other Health problem ☐Yes ☐No ☐Suspected	

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Psychological Health: Does the youth have any of the following concerns?	If yes, please describe.
Physical Abuse ☐Yes ☐No ☐Suspected	
Emotional Abuse ☐Yes ☐No ☐Suspected	
Sexual Abuse ☐Yes ☐No ☐Suspected	
Spiritual Abuse ☐Yes ☐No ☐Suspected	
Physical Abuse ☐Yes ☐No ☐Suspected	
Anti-Social ☐Yes ☐No ☐Suspected	
Grief ☐Yes ☐No ☐Suspected	
Self-Harm ☐Yes ☐No ☐Suspected	
Neglect/Abandonment ☐Yes ☐No ☐Suspected	
Anger/Rage ☐Yes ☐No ☐Suspected	
Shame ☐Yes ☐No ☐Suspected	
Anxiety ☐Yes ☐No ☐Suspected	
Sexual Identity ☐Yes ☐No ☐Suspected	
Sleeping difficulties ☐Yes ☐No ☐Suspected	
Impulsivity ☐Yes ☐No ☐Suspected	
Bed wetting ☐Yes ☐No ☐Suspected	
Self-destructive behaviours ☐Yes ☐No ☐Suspected	
Depression ☐Yes ☐No ☐Suspected	
Suicide ideation ☐Yes ☐No ☐Suspected	
Fire setting ☐Yes ☐No ☐Suspected	
Cruelty to animals ☐Yes ☐No ☐Suspected	
Other psychological challenges ☐Yes ☐No ☐Suspected	

Section 4: EDUCATION INFORMATION		
What school is the youth currently enrolled in?		
P.O. Box/Address:	Town/City:	
Province:	Postal:	Email:
Telephone:	Fax:	
School contact name who know youth:		
When did the youth last attend school regularly?		
Last grade completed:	Grade level youth is currently work at:	
Has the youth completed any psycho-educational assessments? ☐Yes ☐No If yes, please provide detail.		
Does your client have an Individualized Program Plan from their previous school? ☐Yes ☐No If yes, please provide detail.		

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Has the youth ever been expelled or suspended? □Yes □No If yes, please
What things work in helping the youth experience success in school?
What things do not work when getting the youth to complete school work?
What does the youth want to do when they grow up?