**Admission Package**

**YOUTH NAME:** Enter youth being considered for admission.

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| **Section 1: REFERRAL AGENT INFORMATION** |
| Referral Date: Click to enter text. |
| Referral Agent Name: Click to enter text. Position: Click to enter text.  |
| Organization: Click enter text. |
| P.O. Box/Address: Click enter text. Town/City: Click to enter text. |
| Province: Choose an item. Postal: Click to enter text. Email: Click to enter text. |
| Telephone: Click to enter text. Fax: Click to enter text. Cell: Click to enter text. |
| Supervisor Name: Click to enter text. |
| Email: Click to enter text. Telephone: Click to enter text. |
| Please select which program you are applying for admission: (You may select more than one) |
| [ ]  Kihew House, Sturgeon County* 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.
 | [ ]  Stony Creek, Tawatinaw Valley* 7-bed, Rural Co-Ed Treatment Program for youth ages 12-18
* Treatment program supporting abuse history, substance abuse, conflict
* Trauma-informed care integrated into the program
* Healing and skill-building through agricultural experiences, cultural teachings and treatment based on ten dimensions of wellness.
 | [ ]  Grandmother Turtle House, Westlock* 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 Stony Creek.
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| **Section 2: PARENT & GUARDIAN INFORMATION** |
| Mother’s Name: Click enter text. Father’s Name: Click to enter text. |
| Home Address: Click to enter text. Community: Click to enter text. |
| P.O. Box/Address: Click to enter text. Town/City: Click to enter text.  |
| Province: Choose an item. Postal: Click to enter text. Email: Click to enter text. |
| Telephone: Click to enter text. Fax: Click to enter text. Cell: Click to enter text. |
| Legal Guardian Name: Click to enter text. |
| Relationship to youth: Choose an item.  |
| Length and time as Guardian: Click to enter text. |
| P.O. Box/Address: Click enter text. Town/City: Click to enter text. |
| Province: Choose an item. Postal: Click to enter text. Email: Click to enter text. |
| Telephone: Click to enter text. Fax: Click to enter text. Cell: Click to enter text. |
| **Section 3: YOUTH INFORMATION** |
| Surname: Click to enter text. First Name: Click to enter text. Middle Name: Click to enter text. |
| Date of Birth(mm/dd/yy): Click to enter a date. Current Age: Choose an item. |
| Sexual Gender: Choose an item. Identified Gender: Choose an item.  |
| Health Care No (6 digit): Click to enter text. Band No. (Treaty): Click to enter text.  |
| Please provide history of CPS issues / involvementClick to enter text. |
| Does the youth have any criminal history or outstanding charges?[ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| Does the youth have any sexual abuse/deviancy issues? Abused or Abuser? [ ] Yes [ ] No  If yes, please describe by clicking to enter text.  |
| How does the youth/child feel about this placement? Click to enter text. |
| How do the parents/caregivers feel about the placement? Click to enter text |
| Is there any history of the youth being violent/aggressive? [ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| What some of the youth’s strengths? Click to enter text |
| What some interests that this youth has? Click to enter text. |
| What are some of the positive things this youth uses to manage stress? Click to enter text. |
| What are the short- and long-term goals for this youth? Click to enter text. |
| Where do you see this youth living after this current successful placement? Click to enter text. |
| **Section 3: MEDICATION INFORMATION** |
| List any formal medical diagnosis: Click to enter text. |
| Date of last visit to Dentist: Click to enter a date. |
| Dentist Name: Click to enter text. Dentist Contact: Click to enter text. |
| Date of last visit to Optometrist: Click to enter a date. |
| Optometrist Name: Click to enter text. Optometrist Contact: Click to enter text. |
| Date of last Medical visit: Click to enter a date. |
| Current Medical Doctor Name: Click to enter text. Medical Contact: Click to enter text. |
| Date of last Psychiatrist visit: Click to enter a date. |
| Current Psychiatrist Name: Click to enter text. Psychiatrist contact: Click to enter text. |
| Name of Current Medication | Medication dosage | How long has med been prescribed? | Reason for Medication  |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| When was the last time their medication was reviewed? Click to enter a date. |
| Are all immunizations for the youth up to date? [ ] Yes [ ] No [ ] Unsure |
| Is this youth waiting on a specialist appointment? [ ] Yes [ ] No [ ] Unsure If yes, please describe by clicking to enter text.  |
| Current Medical Doctor Name: Click to enter text. Medical Clinic Name: Click to enter text. |
| Medical Doctor contact information: Click to enter text. |
| Does the youth have any allergies? [ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| Is there a current psychologist, psychiatrist and/or other mental health professional engaged with this youth? [ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| Other serious illness history: Click to enter text. |
| Does the youth have a history of suicide attempts? [ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| **Substance Abuse Experience:** Has the youth tried any of the following? |
| Huffing solvent/gas [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Marijuana [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Alcohol [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Cocaine [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Crack [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Ecstasy [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Crystal Meth [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Other [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Has the youth been admitted to addiction treatment before? [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| **Health Concerns:**  Does the youth have any of the following health concerns? |
| Eating Disorder [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Seizures [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Head Injury [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Infectious disease [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Hepatitis [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Diabetes [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Heart Condition [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Gastrointestinal Issues [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Bed wetting [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Sexually Transmitted Infection(s)[ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Physical Disability [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Respiratory Conditions [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Other Health problem [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| **Psychological Health:** Does the youth have any of the following concerns? |
| Physical Abuse [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Emotional Abuse [ ] Yes [ ] No [ ] Suspected | If yes, please describe by clicking to enter text.  |
| Sexual Abuse [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Spiritual Abuse [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Anti-Social [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Grief [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Self-Harm [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Neglect/Abandonment [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Anger/Rage [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Shame [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Anxiety [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Sexual Identity [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Sleeping difficulties [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Impulsivity [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Self-destructive behaviours[ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Depression [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Suicide ideation [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Fire setting [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Cruelty to animals [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| Other psychological challenges [ ] Yes [ ] No [ ] Suspected  | If yes, please describe by clicking to enter text.  |
| **Section 4: EDUCATION INFORMATION**  |
| What school is the youth currently enrolled in? Click to enter text. |
| P.O. Box/Address: Click enter text. Town/City: Click to enter text. |
| Province: Choose an item. Postal: Click to enter text. Email: Click to enter text. |
| Telephone: Click to enter text. Fax: Click to enter text.  |
| School contact name for person who knows youth: Click to enter text. |
| When did the youth last attend school regularly? Click to enter text.  |
| Last grade completed: Click to enter text. Grade level youth is working at: Click to enter text. |
| Has the youth completed any psycho-educational assessments? [ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| Does your client have an Individualized Program Plan from their previous school? [ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| Has the youth ever been expelled or suspended? [ ] Yes [ ] No If yes, please describe by clicking to enter text.  |
| What things work in helping the youth experience success in school? Click to enter text. |
| What things do not work when getting the youth to complete school work? Click to enter text. |
| What does the youth want to do when they grow up? Click to enter text. |