Welcome to Wilp Si'Satxw Community Healing Centre.

Together we can make a difference in delivering quality service to youth who are seeking help for their addictions and collateral issues.

PHILOSOPHY

Wilp Si'Satxw believes that people who are addicted to spirit destroying chemicals can gain power over their addictions. It is with this belief that the primary purpose of Wilp Si'Satxw is to provide a holistic, spiritual-based Healing Centre where people can go through the processes that will start them on the road to recovery. This approach looks at the following realms within an individual as important to the healing journey.

- **Spiritual**
- **Emotional**
- **Physical / Sexual**
- **Mental**

Each person has the ability to confront problem issues and secure their personal power to walk in health and wellness. Each of you are responsible for yourselves and your self healing is a personal choice.

OUR GOALS INCLUDE:

Providing information concerning:

- Alcohol & drug abuse
- Communication
- Alanon
- Traditional native values
- Spirituality
- Self care

The culturally based treatment program assist the participants in learning to use First Nation culture and spirituality as a major tool to maintain sobriety. Out of respect for all belief systems, the spirituality components of the program will not interfere, but will enhance present spiritual beliefs.

DIM SI LAX NOKHL K'UBA WILKSIHLXW

GITXSAN PRINCES AND PRINCESSES
WILL BE STRENGTHENED AND PURIFIED

REFERRAL & ASSESSMENT PACKAGE

REFERRAL WORKER: _____

ADDRESS:

PHONE: _____

FAX: _____

INTAKE DATE: _____

CONFIDENTIAL

CLIENT NAME: _____

CONTENTS

Wilp Participants Please Bring:

- Comfortable clothing for: weather, sweats and exercise
- Personal hygiene items: shampoo, face soap, toothbrush, toothpaste, etc.,
- Sleeping bags, pillows, 3 towels
- Phone/calling cards
- Laundry items: laundry soap cubes, bounce
- Writing material: paper, stamps

I. PERSONAL INFORMATION

Surname_____Given Name_____ Age _____

Address:_____ City:_____ Postal Code_____

Phone: _____ Birth Date(day/month/year)_____Day_____Month_____Year

Sex ○ Male ○ Female Care Card No._____

Band Name_____ Band Number_____

Living on Reserve ○ Yes ○ No If no, where were you raised?_____

Were you raised by Natural Parents? ○ Yes ○ No

If no, give details _____

Marital Status of Parents

○ Single ○ Married ○ Common-law ○ Separated ○ Divorced ○ Widowed

Are you aware of your Native Culture? ○ Yes ○ No

If no, give details

Describe family situation. (Number of siblings; ages)

MEDICAL/PSYCHOLOGICAL

Describe any special needs during program duration

What problem(s) is motivating you to seek help?

What are the most important issues to be addressed within the Wilp Si'Satxw healing program?

What community support is available? (people or agencies)

II. CLIENT HISTORY

Are there any alcohol and/or drug problems in your family of origin? ○ Yes ○ No

If yes, give details

Has there been a death in the family due to substance abuse? ○ Yes ○ No

What is your history and present use of alcohol and/or drugs? (Frequency of use, length of time using, attempts at stopping, etc.)

Describe behavior patterns requiring attention. (i.e. violence, gambling, neglect of family, relationship problems, etc.)

Significant past & present psychological issues relating to alcohol & drug

LEGAL STATUS (PRESENT INVOLVEMENT):

○ Not Applicable ○ Probation ○ Unlocking Aboriginal Justice ○ Other

Explain Situation:

Name and phone number of Probation Officer:

NOTE: COPIES OF ALL DOCUMENTATION PERTAINING TO THE ABOVE MENTIONED MUST BE INCLUDED WITH REFERRAL PACKAGE.

III. SCHOOL HISTORY

1. What school are you attending?_____
2. What grade are you in?_____
3. How would you rate your school attendance? ○ Poor ○ Fair
4. Have you ever seen a school counselor? ○ Yes ○ No
5. Have you ever been on a School Contract as a result of poor behavior? ○ Yes ○ No
   If yes, explain
6. Have you ever been suspended as a result of using drugs or alcohol in school? ○ Yes ○ No
   If yes, explain
7. Please list any other significant events relating to school
8. Did your parents attend Residential School? ○ Yes ○ No
9. Did your grandparents attend Residential School? ○ Yes ○ No

IV. CONSENT FOR TREATMENT

I, _____(name of client), agree to enter the Wilp Si'Satxw Community Healing Centre, P.O. Box 429, Kitwanga, B.C., V0J 2A0, for the purpose of treating my alcohol/drug dependency problem.

My reason(s) for applying for admission to the Wilp Si'Satxw Healing Centre is:

I would like to learn about:

For admission to the Wilp Si'Satxw Healing Centre, you must:

- be able to participate fully in the program
- complete all intake and medical forms
- abstain from the use of alcohol and non-prescribed drugs

I understand and agree to accept the conditions of this program as outlined.

Signature of Applicant: _____

Parent/Guardian Signature: _____

Date: _____

V. WAIVER

As the legal guardian for, _____ ,

I, _____ , hereby agree to render and save harmless from all liability all staff, volunteers, and board members of the Wilp Si'Satxw Society for any accidental injuries and/or any losses of, or damage to, any personal property which may occur throughout the duration of his or her stay at the Wilp Si'Satxw Healing Centre.

Student/Client Signature: _____

Parent/Guardian Signature: _____

Date: _____

VI. PRE-ADMISSION MEDICAL EVALUATION

Client's Name: _____ Medical #_____

CLIENT RELEASE

I, _____ , hereby request and permit my physician to release medical facts and assessment about me to _____ and Wilp Si'Satxw Society. The photocopy of my signature on this form is as valid as the original.

Client's Signature:_____ Parent/Guardian:_____

TO THE PHYSICIAN

The above named client is to be medically assessed as a potential participant in our residential life-skills program. Our program is designed to help people who acknowledge that drinking or drug use has interfered with their effective functioning and who are physically and mentally ready to participate in a program of intense counseling activity.

MEDICAL EXAMINATION

1. Date of last alcohol use_____
2. Date of last psychoactive drug use _____
3. Current Diagnosis_____
   Current Medication(s)_____
4. Medical problems to be followed while in treatment (MD is available for follow-up)
   _____
5. Any allergies? _____ If so, what?_____
6. If female, date of L.M.P. _____ Is patient pregnant? ○ Yes ○ No
7. Date of latest chest x-ray, if known, and result. (Please note, if last chest x-ray more than one year ago, it is mandatory for client to have had a chest x-ray before coming to treatment).
8. Functional inquiry - is there any disorder of the following?

Hair, skin, nails (especially current to recent infestations or infections)	○ Yes	○ No
Ear, nose, throat	○ Yes	○ No
Muscular-skeletal system	○ Yes	○ No
Blood, lymphatic system	○ Yes	○ No
Cardio-vascular system	○ Yes	○ No
Respiratory system	○ Yes	○ No
GI system	○ Yes	○ No
GU system	○ Yes	○ No
CNS - especially HX of seizures	○ Yes	○ No
Past history of TB	○ Yes	○ No

9. Family History

Alcohol/drug problem	○ Yes	○ No
Psychiatric history	○ Yes	○ No
Adopted	○ Yes	○ No

10. Physical Examination

Height _____ Weight _____ BP/PR_____

	NORMAL	ABNORMAL
Appearance		
ENT		
Hair, skin, nails		
Muscular-skeletal system		
Thyroid		
Cardio-vascular system		
Respiratory system		
Abdomen		
Central nervous system		
Evidence of sexually transmitted disease		

11. Please comment on any abnormalities noted above.

_____

12. Have you any comments, suggestions or insights that might be helpful in terms of client's being physically and mentally able to participate in group, one-to-one counseling and living in residence for six weeks?

_____

AS PER PRE-REQUISITE TO TREATMENT YOUR PATIENT MUST:

1. Be free from all communicable diseases (i.e. STD, Scabies, lice) ○ Yes ○ No
2. Have a negative T.B. test in the last 6 months Pos.○ Neg.○ Date:_____
3. Be clean and sober from alcohol and all psychoactive medications/drugs (all mood or mind altering substances) for a minimum of 14 days ○ Yes ○ No

   Date of last use (Alcohol)_____ (Drugs)_____

A copy of recent lab work, if available, would be appreciated e.g. CBC, liver functions, FBS etc....

I have examined this client and find him/her to be fit to attend treatment.

Physician's Signature _____

Address _____ Date _____

Telephone No. _____ Fax No. _____

NOTE: PLEASE PRINT CLEARLY