Shunda Creek Recovery Centre

APPLICATION CHECKLIST

Please review the following criteria to ensure viability for the program before applying.

- 18-26 years old
- Male
- Alberta resident with an active provincial healthcare number.
- Physical ability to engage in wilderness-based activities.
- Stable on medications with no medications that are on the restricted medication list (attached).

Any questions related to the program or eligibility please contact the Shunda Creek Intake Coordinator 403-826-3692

The following forms make up the application package. Please ensure you have completed and enclosed all the items listed below. If an incomplete application is received the application will be placed on hold until all forms are submitted.

- Application Form- Completed by client – 4 pages
- Medical Form- Completed by a Physician - 3 pages
- Physician's Information Form- Physician signature required – 1 page

Please note that 2-4 preadmission sessions will be completed via virtual or telephone appointments. Please include an active phone number to reach the applicant.

Submit your complete application package to the Shunda Creek Intake Coordinator via;

Email – Shundaintakecoordinator@enviros.org

The client will be contacted within 2-4 business days to set up their first virtual appointment.

Shunda Creek Recovery Centre is a fully funded program, there is no cost to attend.

Program Application

Client Information						
Last name		First name		Birth date *(yyyy-Mon-dd)*		Age
Address			Mailing Address			
City	Postal Code		Phone Number		Alternative Phone Number	
Alberta Health Care #		Gender ☐ ____________		Marital Status		
Are you pregnant? ☐ No ☐ Yes ▶ Due date *(yyyy-Mon-dd)* ____________ Have you received prenatal care? ☐ No ☐ Yes					Do you have children? ☐ No ☐ Yes	
Do you have any special needs? *(Reading/writing English, wheelchair accessibility, hearing difficulties, etc.)*						
Cultural Identity: The following question is asked in order to improve its services to individuals from a variety of cultural/ ethnic backgrounds. If you identify yourself with a particular ethnic or cultural group(s), please tell us which one(s). ☐ Specify ____________ ☐ I do not identify with any ethnic or cultural group.						
Indigenous ☐ Treaty status ☐ On-reserve ☐ Off-reserve ☐ Metis ☐ Non-Status ☐ N/A Treaty No. *(10 digits)* ____________ Band Name ____________						
Emergency contact/Next of Kin *(Last name, First name)*						
Relationship to you			Phone Number		Alternate Phone Number	
Where will you live after treatment?						
Referring Worker *(Last name, First name)*						
Referring Office *(Name)*						
Phone Number		Fax Number		Other		

ENVIROS

Program Application

Education/Employment History
Last grade/college level completed
☐ None ☐ Gr. 1-6 ☐ Gr. 7 ☐ Gr. 8 ☐ Gr. 9 ☐ Gr. 10 ☐ Gr. 11 ☐ Gr. 12/13
☐ Trade School/Labour Ticket ☐ College/Tech. Diploma ☐ University degree
Are you considering further education? ____________________
What is your current employment status?
☐ Unemployed ☐ Employed Part-time ☐ Employed Full-time ☐ Student
☐ Self-Employed ☐ Disability ☐ Other ____________________
If employed, what is your occupation? ____________________

Legal Involvement/History or Trauma or Violence	
Are you attending this treatment under any of the following conditions	
☐ Probation ☐ Temporary Absence ☐ Court order ☐ Drug Court ☐ Statutory Release	
☐ Out on bail ☐ Own recognizance ☐ Child and Family Services conditions ☐ Employer	
If attending treatment due to legal involvement, what is the offense? ____________________	
List of conditions ____________________	
Do you have any upcoming court dates, community service hours, or are you on a parole or probation, etc? *(please provide specifics)* ____________________	
Probation Officer or Child and Family Services worker *(Last name, First name)*	
Phone Number	Fax Number
Do you identify with a history of trauma? ☐ No ☐ Yes	
Domestic violence ☐ No ☐ Yes	
Sexual violence ☐ No ☐ Yes	
Have you ever become aggressive or have history of violence in/with	
☐ Intimate relationships ☐ Friends/acquaintances ☐ Work relationships	
☐ Strangers ☐ Relatives ☐ Other drivers on the road	
Do you have a history of illegal fire starting? ☐ No ☐ Yes	

ENVIROS

Program Application

Substance Use/Gambling History

Other addiction to concerns?

☐ Video games/TV ☐ Sex/Pornography ☐ Food ☐ Gambling

☐ Shopping ☐ Relationships ☐ Other ____________________

Tobacco use

Do you smoke or use smokeless tobacco? ☐ No ☐ Yes

Are you interested in quitting while in treatment? ☐ No ☐ Yes

Note: Shunda Creek is a tobacco free site

What are the most important areas for you to address in treatment?

____

____

Are your family and/or significant others involved in your treatment? ☐ No ☐ Yes

Is your family aware of the opportunities for involvement? ☐ No ☐ Yes

Will your family be attending the family component of the program? ☐ No ☐ Yes

What would stop your family or significant others from becoming involved? ____________________

____

____

Medical Health Information *(Medical form to be completed by Physician)*

Medications *(prescription and over the counter)* being used *(please provide information about what the medication is prescribed for, frequency of use, etc.)*

____

____

____

____

____

____

____

____

If prescriptions are required, how will they be paid for? *(SFI client #, Blue Cross, etc.)*

____

____

____

____

Are there any physical limitations that would prevent you from participating in treatment programming?

____

____

____

____

Program Application Young

Mental Health Information		
Use Mental Health Assessment, as per Zone		
Do you have any history of self-harming behaviours, including cutting? ☐ No ☐ Yes ► provide information, such as how current the thoughts or behaviors are		
Do you have a history of restricting food intake or bringing and purging? ☐ No ☐ Yes ► provide information, such as specific behavior and how current they are		
If currently under the care of Psychiatrist/Psychologist		
Last Name	First Name	Phone
Previous psychological assessment attached ☐ No ☐ Yes		
Referring Person *(Last name, First name)*	Signature	Date *(yyyy-Mon-dd)*

Medical Assessment

There is **no cost** to completing this medical.

Last Name		First Name	
Personal Health Care number			Phone
Family Physician's *(Last name, First name)*			Phone
Are you the applicant's regular Physician? ☐ No ☐ Yes			
Date of last examination *(yyyy-Mon-dd)*		Date for follow up *(yyyy-Mon-dd)*	

Does this person have or has he/she ever been treated for	**No**	**Yes**	**Please elaborate re: impact on current functioning.**
Loss of consciousness or coma			
Frequent, chronic or severe headaches			
Blackouts			
Head injuries/serious falls/car accident			
Childhood/adult illness-high fever/serious infection			
Epilepsy *(seizures)*			
Dizzy spells			
Allergies/Asthma -please indicate specifics. *(What/Severity/Treatment)*			
Sleeping disorders			
Heart disease or heart problems			
Stroke			
Tumors			
Diabetes			
Cancer			
Abdominal or stomach problems			
MRSA			
Back problems/joint problems			
Skin disorders			
HIV			
Hepatitis			
Sexually transmitted infections/ Last tested?			
Lung conditions/respiratory problems			
Does applicant smoke?			
Glasses/contact lenses/visual problems			
Hearing impaired			
Presence of/exposure to communicable disease			
Any other medical conditions/symptoms			
Pain ☐ acute ☐ chronic			
Pregnancy			
Addiction or substance abuse/ever use IV drugs			
If yes Comments			
Has applicant been hospitalized in the last year?			
If hospitalized, please list dates, reasons, length of stay.			

ENVIROS

Medical Assessment

Psychiatric History

Has this patient ever seen a psychiatrist? ☐ No ☐ Yes ▶ Who ____________________
When *(Date yyyy-Mon-dd)* ____________

Diagnosis	Treatment

Are any of the following present?

Delusions/Hallucinations ☐ No ☐ Yes ▶ ____________________

Confusion/disorganized Behaviours ☐ No ☐ Yes ▶ ____________________

Suicide Risk/Attempts ☐ No ☐ Yes ▶ When *(Date yyyy-Mon-dd)* ____________
Method ____________________
Treatment provide ☐ No ☐ Yes

Are any of the following sufficiently impaired to interfere with emotional or cognitive functioning

Memory	☐ No	☐ Yes	Attention	☐ No	☐ Yes	Concentration	☐ No	☐ Yes
Impulse Control	☐ No	☐ Yes	Verbal Skills	☐ No	☐ Yes	Abstract thinking	☐ No	☐ Yes
Judgment	☐ No	☐ Yes						

Comments

Medications ***(Complete if Addictions Counsellor don't have access to the Netcare (Medication Reconciliation)***

Name	Prescribing Doctor	Dose/frequency	How long has patient been on this medication? Date Prescribed *(yyyy-Mon-dd)*	As treatment for what?

Medical Assessment

Restricted Medications ***(If a restricted medication is recommended by a physician for a compelling medical reason, each site will consider on a case-by-case basis. a signed Physician letter must be included with this form for any exceptions)***				
Name	Prescribing Doctor	Dose/frequency	How long has patient been on this medication? Date Prescribed *(yyyy-Mon-dd)*	As treatment for what?
Comments/Potential Side Effects				
Medication Taper Plan				
If you are aware of any concerns/issues that should be taken into account in the treatment of the applicant, please indicate and give details				
Comments				
Physician's Signature		Date *(yyyy-Mon-dd)*	Physician's Stamp	

PHYSICIAN INFORMATION

___________________________ has applied to enter into a 12 week addiction recovery program provided by Enviros Wilderness School Association. The wilderness based program is located in the Shunda Creek area east of Nordegg Alberta. As a wilderness based program, treatment is delivered individually and in group settings at the camp site as well as in the wilderness. As part of treatment ___________________________will be expected to participate in a variety of recreational and wilderness activities. These activities are not designed to be extreme; however, a reasonable level of health and ability is required to participate.

___________________________may be exposed to situations and environmental conditions where the stresses and hazards may be greater or different than those normally encountered. Activities that may be utilized while in an Enviros Wilderness School Association program may include, though are not limited to day hiking, multi-day backpacking trips, top roped climbing (indoor, rock and ice), canoeing (lake and river), rafting, cross-country and downhill skiing, experiential activities, low and high ropes courses, swimming, and mountain biking.

Please take this in to consideration when you assess ___________________________as part of his treatment application.

Physician, please sign as read and return with completed medical form.

Physician Signature: ___________________________________ Date: ______________
(dd-mmm-yy)

Print Name: ____

Respectfully,

Enviros
Shunda Creek
403-721-3918

Shunda Creek Recovery Centre
Restricted Medications List

The following medications are restricted at Shunda Creek Recovery Centre
*(Note: this list is not exhaustive and other medications may be subject to restriction) *

Opioid Pain Medications

- Morphine (e.g. Kadian)
- Fentanyl
- Hydromorphone (Dilaudid)
- Oxycodone (Percocet, OxyNeo)
- Meperidine (Demerol)
- Codeine & Codeine products (e.g. Tylenol #3)
- Tapentadol (Nucynta)
- Pentazocine (Talwin)
- Propoxyphene (Darvon)
- Tramadol (Zytram, Ralivia, Triural)

Benzodiazepines

- Alprazolam (Xanax)
- Bromazepam (Lectopam)
- Lorazepam (Ativan)
- Oxazepam (Serax)
- Temazepam (Restoril)
- Triazolam (Halcion)
- Clonazepam (Rivotril, Klonopin)
- Chlordiazepoxide (Librium)
- Clorazepate (Tranxene)
- Diazepam (Valium)
- Nitrazepam (Mogadon)
- Flurazepam (Dalmane)

Sedatives/Hypnotics/Sleeping Medications

- Secobarbital (Seconal)
- Chloral Hydrate (Aquachloral, Chloralum, Somnote)
- Ethchlorvynol (Placidyl)
- Glutethimide (Doriden, Elrodorm, Noxyron, Glimid)
- Methyprylon
- Zopiclone (Imovane, Zimovane)
- Eszoplicone (Lunesta)
- Zaleplon (Sonata)
- Zolpidem (Ambien)

Other Substances

- Synthetic Cannabinoids (Nabilone/Cesamet, Dronabinol/Marinol)
- Cold Medications (Decongestants, anti-cough meds)
- Electronic cigarettes
- Tobacco products
- THC, CBD, CBG products

Updated Fall 2023

<u>Psychostimulants-</u> At Shunda Creek we recognize that the use of Psychostimulant medication for ADHD management can be a valuable tool for recovery. Therefore, we will allow the following medications if clients have been stable at a maintenance dose for at least 6 weeks.

- Dextroamphetamine (Dexedrine)
- Amphetamine mixed salts (Adderall XR)
- Lisdexamfetamine (Vyvanse)
- Methylphenidate (Ritalin, Biphentin, Concerta)

Med Changes & Stability

All participants will need to be stable on medications for six weeks prior to entering the Shunda Creek Recovery Centre. We are unable to accommodate medication changes during your 90 day treatment. If dose or type of medication needs to be changed while in program a treatment leave will be arranged to do so in your home community.

What if I am taking Methadone or Suboxone for opioid dependence treatment?

Sublocade and Suboxone are accepted at Shunda Creek Recovery Centre. Clients will need to be stable at their maintenance dose for at least 1 week prior to intake. The preadmission counsellors will work with ODP clinics to ensure the prescription is in place for the 90 day treatment cycle.

What about Vitamins and Supplements that support my recovery?

Vitamins (i.e. vitamin B) and supplements (i.e. melatonin) can only be used with a Dr’s prescription. The product must be brought to treatment in a sealed container. Please ensure you have enough to cover the 90 days in program.

What if I am currently on a restricted Medication?

- With physician guidance and supervision, you may be able to discontinue the medication for the duration of your treatment. We suggest making a plan with your physician to taper off any medications.

- You can request from your physician an alternative medication that is not on the restricted medication list.

Please note that any medication changes require a 6 week stabilization period prior to intake