KAINAI TRANSITION CENTRE SOCIETY

COMMUNITY CORRECTIONS 403-737-2555
JOB READY 403-737-2666
TRANSITION SUPPORT 403-737-2666

P.O. Box 530, Standoff, Alberta T0L 1Y0 • Fax 403-737-2000

REFERRAL APPLICATION FOR RESIDENCY

(AS THE REFERRAL AGENCY PLEASE COMPLETE APPLICATION WITH CLIENT, INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED)

REFERRAL INFORMATION

DATE APPLICATION FAXED: _____

PERSONAL INFORMATION

Name: _____ Date of Application: _____

Birth Date: _____ Age: _____ Gender: M ☐ F ☐

Address: _____

Phone #: (Home): _____ (Cell):_____

Can we contact you at the number(s) you have provided? Yes ☐ No ☐

Name of First Nation: _____ Treaty # _____

Province: _____ Health Care. #: _____

In case of emergency who would you like us to contact. _____

Relationship: _____ Phone # _____ Alternate # _____

Family Doctor: _____ Phone #: _____

Clinic Name & Clinic Address: _____

TYPE OF REFERRAL:

A. Treatment Centre to ***KAINAI TRANSITION CENTRE SOCIETY***

   a. Treatment Completion Date: _____

   b. Successful Discharge Summary Attached: YES ☐ NO ☐

   c. Certificate of Treatment Completed: YES ☐ NO ☐

Name & Address of **Treatment Centre**: _____

Name of Treatment Centre Counsellor: _____ Phone: _____

Email/Fax Number: _____ Date of Referral: _____

Days at Treatment Centre: _____ OR Bed Confirmation Date: _____

Any reason for Early Discharge? Dismissal? (Please explain): _____

B. Transition to Treatment Centre-**NAME OF TREATMENT CENTRE**: _____

a. With **BED CONFIRMATION DATE**: _____

Name & Address of NNADAP Center: _____

Name of NNADAP Counsellor: _____ Phone: _____

Email/Fax: _____ Date of Referral: _____

C. Doctor Referral-**Name of Doctor**: _____

Name of Doctor: _____

Name of Clinic & Clinic Address: _____

Reason for Referral: _____

_____

D. Other: Please explain: _____

Contact Information: _____

Reason for Referral: _____

FAMILY RELATIONSHIPS & CHILDCARE STATUS

Relationship Status: Single Common Law Married Divorced Other: _____

Children/Dependents: Yes ☐ No ☐

If **YES**: Do the children have adequate childcare while client is in Residence? Please Describe: _____

_____

Is there any current Child & Family Services involvement? Yes ☐ No ☐

If **Yes**, please describe: _____

Children Services Plan Attached: Yes ☐ No ☐

SUBSTANCE ABUSE PROFILE

Substance(s) of Choice	1.	2.	3.

MENTAL HEALTH PROFILE

Been diagnosed with Mental Disorders: Yes ☐ No ☐ Please explain: _____

Currently being treated for a Mental Disorder: Yes ☐ No ☐ Please explain: _____

On medication for the any of the above listed: Yes ☐ No ☐ Please list: _____

Previous suicide attempts?: Yes ☐ No ☐ When: _____

Hospitalized for Suicide Attempts? Yes ☐ No ☐ When: _____

History of Self Harm? Yes ☐ No ☐ When: _____

MEDICATIONS:

Is client currently prescribed:

Methadone Yes or No **Suboxone** Yes or No

Prescribing Physician: _____

Physician Phone Number: _____

Physician Address: _____

Prescribed Dosage: _____

How Long on Medication: _____

Other Prescribed Medications & Dosage: _____

_____

_____

_____

LEGAL ISSUES

(If client has pending charges or warrants, they must be willing to deal with these legal matters while residing at Kainai Transition Centre Society)

Does client have any pending charges or outstanding warrants? Yes ☐ No ☐

If Yes, what are the charges (please list): _____

_____

Does client have any pending and/or upcoming Court Dates? (please list date/time/place.): _____

_____

_____

Is client willing to submit name to Blood Tribe Police Service for a Warrant check? (Please note any non-disclosure of pending/current legal matters, will result in application being deferred or till ALL LEGAL MATTERS have been resolved.)

PROVINCIAL CORRECTIONS (INCARCERATED)

Name of Correctional Institution: _____

Select One: **Remand** ☐ **Sentenced** ☐

a. **REMAND** – When is next court date or expected release date? _____
b. **SENTENCED** – If sentenced, Date of Release: _____

Brief description of Current and Pending Charges: _____

_____

What are the Release Conditions? (Brief description): _____

_____

_____

FEDERAL CORRECTIONS (INCARCERATED)

Name of Correctional Institution: _____

SECTION 84: Yes ☐ No ☐ IF **NO**, PLEASE EXPLAIN: _____

_____

_____

_____

Type of **Parole** Inmate is applying for:

_____

COMMUNITY LETTER TO ***BLOOD TRIBE CHIEF & COUNCIL-KAINAI TRANSITION CENTRE SOCIETY***:

☐ Copy Attached Date Mailed: _____

DESCRIBE CLIENTS REASON FOR WANTING TO ATTEND THE KAINAI TRANSITION SUPPORT PROGRAM?
(Please have client fill out this section)

Client Name (Please Print): _____

Client Signature: _____

Date of Application: _____

Referral Worker Name (Please Print): _____

Date of Referral: _____

Name of Referral Agency: _____

Phone No.: _____ Email: _____