2nd Floor Women's Recovery Centre

4823-50th Street
P.O. Box 479
Cold Lake, AB
1.780.594.9903 (p) 1.877.594.5454(t-f)
1.780.594.9907 (f)

TREATMENT REFERRAL PACKAGE

~Program Information~ ~Referral Forms~

The **2nd Floor Women's Recovery Centre**, operated by **the Lakeland Centre for FASD**, is a unique long term residential treatment program exclusively for women who are using substances and want to make a positive change in their lives. The **2nd Floor** is a gender responsive program which recognizes that addictions in women are complex across the various roles that a woman plays in society.

Our mission at the **2nd Floor** is to help women break the cycle of addiction and to reduce the number of babies born prenatally exposed to alcohol and other drugs (AOD) in Alberta. It is estimated that a baby a day is born in Alberta with FASD: FASD is a permanent condition, one that cannot be reversed and often goes without diagnosis.

The **2nd Floor** is available to women as young as 15 years of age from anywhere in Alberta. A woman may make application anytime throughout their pregnancy, the earlier the better. Due to the complications in detoxification, especially during pregnancy, we are unable to provide detox at the 2nd Floor. Pregnant clients are required to attend a 5-7 day medically supervised detox program. Non-pregnant client who are unable to maintain sobriety prior to their intake date are also encouraged to attend a 5-7 day medically supervised detox program.

At the **2nd Floor**, each woman will have a private room with access to an Addictions Counsellor, Case Manager, Programmer, Health Services, and other community consultants and service providers. We are unable to provide support or accommodations for client partners or children.

Upon Admission, each client will be seen by Health Services to provide a medical baseline and, if necessary, a prenatal exam. Each client will meet with the Program Staff team to develop an Individual Recovery Program (IRP) which will include one-to-one and/or group sessions with the Addictions Counsellor, Case Coordinator, Programmer and other services as needed. Strengths and needs will be

identified, such as housing, finances, health, relapse prevention, parenting decisions, and a natural discharge date determined.

Each woman will be transitioned to their home community/community of choice, approximately one month prior to their delivery date, according to their After Care Plan; she will be provided information regarding types of services available in their community, as well as referred to a local PCAP office if available. Self-discharge is a choice of each woman, but it is not recommended.

The **2nd Floor** employs two primary treatment philosophies: Harm Reduction and Relational Theory. The 2nd Floor approach to alcohol and pregnancy is that no alcohol is best when pregnant, planning to become pregnant or nursing. Harm Reduction recognizes that not all women are able to completely abstain from the use of alcohol and other drugs. Women will be provided with information regarding the impact of continued use of Alcohol and other drugs on their person, their fetus, and women will be encouraged to engage in proven preventative measures to prevent future births of children prenatally exposed to alcohol.

A unique aspect of the **2nd Floor** is that a woman will not necessarily be discharged due to relapse: each situation will be evaluated on an individual basis. Relational Theory speaks to the various roles women play in society and how various experiences and relationships contribute to addiction. The development and support of healthy positive relationships fosters a new direction in women who have chosen to attend the 2nd Floor.

Please find attached the **2nd Floor Women's Recovery Centre** *Client Referral Package*. Please utilize this package only for referrals: it may be completed as a PDF or manually completed. We appreciate your cooperation and effort to assist women in their recovery process.

This package contains program information, referral process and application form, and admittance procedures. Please make copies of this Referral Package for future use.

Please ensure all areas of the referral forms are completed in full. Missing information will delay the process. We require:

- ✓ Referral Information Form (Referral Source or Self-Referral);
- ✓ Pre-Admission Form (signed by client and referring agency);
- ✓ Detox information/Admissions Medical form from supervising physician;
- ✓ Consent to Release of Information;

Thank you for considering **2nd Floor Women's Recovery Centre**. If you have further inquiries regarding our intake procedure, please do not hesitate to call, 1.780.594.9903 or 1.877.594.5454(t-f)

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FEES

The 2nd Floor Women's Recovery Centre Fee Schedule is as follows:

- $40.00/day
- Payee will be invoiced by the LCFASD Accounts Manager at month's end;
- Self-Pay users will be required to pay the Fee Schedule at the beginning of the month;
    - If a Self-Pay user self-discharges before month's end, fees are *non-refundable*;
    - If a Self-Pay user is scheduled to be discharged before month's end, the Fee Schedule will be reduced accordingly;
- Fees may be paid by:
    - Cash
    - Certified Cheque
    - Electronic Funds Transfer (EFT)
- If a Client self-discharges the funder will be invoiced $80 (2days) to hold the bed in the event of their return.

REFERRAL PROCESS/APPLICATION FOR TREATMENT

Client may self-refer or be referred by any social agency.

ACCEPTED PHYSICIAN PRESCRIBED TREATMENTS

2nd Floor is able to provide alternative Physician prescribed treatments including:

- Opioid Agonist Therapy
    - Methadone Maintenance
    - Suboxone
- Medical Marijuana
    - This will be considered on a case by case basis

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EXCLUSION OF SERVICES

At this time, the 2nd Floor is unable to provide treatment services to women who require:

- ***Psychoactive medications*** but *refuse* to take them
- ***Opioids*** or ***prescription narcotics*** and refuse
  - Medication replacement must be established and in place prior to arrival at the 2nd Floor
- Accommodations for spouse/partner and/or children

INTAKE PROCEDURES

- Completion/submission of the **Referral Package**;
  - ***Admission Medical*** is a necessary document
- Telephone interview with the referral source and/or the client;
- Applications will be screened prior to approval;
- Attendance at & completion of a medically supervised detoxification program, due to the inherent risks of detoxing while pregnant, is required. Please advise if assistance from 2nd Floor staff is required.

PRE-TREATMENT CRITERIA

Prior to attending the 2nd Floor Women's Recovery Centre, clients must:

- Complete a ***medically supervised detox program***;
  - Pregnant clients MUST complete a 5-7 day medically supervised detox program;
  - Non-pregnant clients are encouraged to attend a 5-7 day medically supervised detox program as detox is not available at the 2nd Floor;
- Clients who are either taking prescription narcotics must either:
  - Detox from the prescribed medication altogether;
  - Wean off the prescription narcotic and have Physician replace with non-narcotic medication **prior to admission**;

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- Complete the ***Admissions Medical*** which is a comprehensive medical report identifying chronic health issues, sexually transmitted infections and treatments etc. to ensure the 2nd Floor Health Services is aware of the client's medical concerns & needs;
- Be determined to live a healthier way of life;
- Be able & demonstrate willingness to participate in treatment;
- Review & be willing to abide by the 2nd Floor Women's Recovery Centre's program guidelines;

The Referral Agency can assist their client in preparing for admission to the 2nd Floor Women's Recovery Centre by:

- Reviewing the treatment process with client, familiarize client with alcohol/drug treatment programs, house policies, resident's rights/responsibilities and 2nd Floor expectations of the client;
- Assist the client in completing the Referral Package, providing required documentation and funding information;
- Providing information in regards to their client's After Care Plan as part of their Individual Recovery Plan.

ADMISSION PROCESS

- Monday-Thursday are admission days at the 2nd Floor;
    * There will be ***no*** admissions Friday-Sunday or on holidays;
    * Any transportation delays must be reported as soon as possible by the worker or client. If we do not receive information of delays, this may result in loss of bed space;
- If a client changes their mind regarding admission, please advise us as soon as possible;
    * If a client cancels their admission, the application will be kept on file, but they will need to reapply;
- If a client arrives **without having received acceptance notification**, this client **cannot** be admitted into the accommodations treatment program. The client will be required to make alternate arrangements and to contact their referral source;

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DRUG & ALCOHOL TESTING

- Detox Program will be requested to forward client's Drug & Alcohol test results (completed prior to discharge);
- On arrival a Drug Test & Alcohol Swab will be completed;
    * Drug & Alcohol tests used at the 2nd Floor are Positive or Negative for use;
- If a client tests positive for drugs &/or alcohol, she will not be able to remain at the 2nd Floor.
- Clients who demonstrate signs of intoxication or withdrawal will not be admitted to the 2nd Floor;
    * Appropriate arrangements will be made based on individual circumstances for women who are unable to remain at the 2nd Floor.

CLIENT NO SHOW

- Admission Days are Monday-Thursday. In the event that a client does not arrive, the referral source will be contacted and advised the client did not arrive for admission;
- Any no shows will be considered a cancellation: beds will be filled by those on the wait list;
- If a client calls to cancel, client will be asked to contact their referral source.

WAITLIST MANAGEMENT

- Clients appropriate for our program will be put on a **WAIT LIST** until a bed becomes available. The client is encouraged to continue preparing for treatment by engaging in pre-treatment services;
- **Once a bed is available, the client will be contacted by phone and an acceptance letter will be sent to the referring agency as well as the client, if possible;**
- One week prior to admission, we will conduct a telephone interview with the client and receive an update on Pre-treatment services and/or client readiness;
- Travel arrangements to and from the Centre, are the responsibility of the referral worker or client, and must be confirmed with 2nd Floor staff;

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* The 2nd Floor may be able to facilitate transportation in certain circumstances. If transportation is an issue, contact the 2nd Floor.

RE-ADMISSION

- Re-admission is defined as a request to return to the program after having chosen to self-discharge against the advice of the 2nd Floor or after having gone AWOL;
- Requests for re-admission will be processed on an individual basis. A file review and meeting with the Program Team will be required.

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PLEASE RETAIN A COPY OF APPLICATION FOR YOUR RECORDS

REFERRAL AGENCY INFORMATION

Name of Client: _____

DOB: _____

Name of AGENCY: _____

Address: _____

Email: _____

Name of REFERRAL WORKER: _____

Phone#: _____ Fax#:_____

To prepare the client for Residential Treatment Programming, please list the *medically supervised* Detox Program this client will be attending, include agency, name of worker, type of service provided:

_____
_____

TREATMENT FUNDING INFORMATION

Please provide the agency/service/group/etc. that will be providing treatment funding for this client:

Name: _____ File#: _____

Address: _____

Contact: _____

Phone#: _____ Fax#:_____

Email: _____

BENEFIT INFORMATION

Name of Provider: _____

Client File#:_____

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AFTERCARE PLANNING

Will you be involved in this client's after care plan?

☐ YES OR ☐ NO

If yes, describe:

Have aftercare & follow-up plans been made between the client & worker?

☐ YES OR ☐ NO

If yes, describe:

Will any support or counselling be offered to the family while the client is in treatment for recovery/healing initiatives?

☐ YES OR ☐ NO

If yes, describe:

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Additional Comments:

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PLEASE RETAIN A COPY OF APPLICATION FOR YOUR RECORDS

The 2nd Floor Women's Recovery Centre

Referral Information

Last Name: _____ First Name: _____

Birth Date: _____

Address:_____

Postal Code: _____

Phone#: _____

Health Care #:_____ Benefits#: _____

Current Physician: _____ Phone#: _____

In Case of Emergency Contact: _____

Relationship: _____

Emergency Contact Address: _____

Emergency Contact Phone#: _____

Cultural Identification:

☐ Caucasian ☐ Black ☐ Asian ☐ Ukrainian ☐ French

☐ Other _____

Aboriginal Ancestry: ☐ YES ☐ NO

☐ Status ☐ Non-Status ☐ Métis ☐ Inuit

Name of Band: _____ 10 Digit Band #:_____

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PRESENT HEALTH

Family Planning

Is client currently on birth control? ☐ Yes ☐ No

What method? _____

Important info (i.e. date of next depo shot)

_____

Is client Pregnant? ☐ Yes ☐ No

Estimated Due Date: _____

Pregnancy History

Please include live births, miscarriages & terminations

Previous Pregnancy	Date	Concerns/Complications

Heart Disease ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Communicable Disease ☐ Yes ☐ No (i.e. HIV, STDs, HEP A/B/C, TB)

Additional Information:

_____
_____
_____
_____

Allergies ☐ Yes ☐ No

If yes, please list (food, medication, environmental)

_____
_____
_____
_____

Is a special diet indicated? ☐ Yes ☐ No

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Have you had extended medical treatment? ☐ Yes ☐ No

Any previous diagnosis or referrals for diagnosis? ☐ Yes ☐ No

(*Please attach copy of diagnosis if important to treatment*)

If yes, please indicate diagnosis:

_____
_____
_____
_____

Additional Medical Information:

_____
_____
_____
_____

MENTAL HEALTH

A Progress or Assessment Report from the Psychiatrist, Physician, or Mental Health Counsellor, Therapist may be required for any client referred who has mental health condition/diagnosis.

Do you have a history of mental health conditions? ☐ Yes ☐ No

Condition Presented:

_____
_____
_____
_____

Please provide details: (date of diagnosis/conditions, current status)

_____
_____
_____
_____

Do you have a history of suicidal ideations/attempts? ☐ Yes ☐ No

If yes, provide details; include dates, method, factor(s) leading to ideation/attempt:

_____
_____
_____
_____

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Please provide details of intervention/counselling services provided at that time?

_____
_____
_____
_____

MEDICATIONS (please use additional paper if necessary)

Please provide a typed copy of all current prescriptions

Current Medications	Purpose

Past Medications (pertinent to pregnancy & treatment):

_____
_____
_____
_____

CURRENT SUBSTANCE USE (please use additional paper if necessary)

Substance	Frequency of use	Quantity of use	Duration of use	Situation/Triggers of use

SUBSTANCE USE HISTORY (please use additional paper if necessary)

Substance	Age of first use	Date of last use	Frequency of use	Quantity of use

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PRIOR ALCOHOL & DRUG ABUSE TREATMENT

IN-PATIENT TREATMENT PROGRAMS

Please list treatment programs Client has attended beginning with the most recent. If more space is required, please copy this page.

Recommendations or Reports may be requested from the Facility to assist in the development of your Individual Recovery Plan.

Admission Date: _____

Duration: _____

Name of Facility: _____

City:_____

Length of Treatment: _____

Type of Treatment: _____

Presenting Problem:

_____

Was treatment completed? _____

If no, state reason: _____

Duration of Abstinence following Treatment:

_____

_____

_____

Admission Date: _____

Duration: _____

Name of Facility: _____

City:_____

Length of Treatment: _____ Type of Treatment: _____

Presenting Problem:

_____

Was treatment completed? _____ If no, state reason:

_____

Duration of Abstinence following Treatment: _____

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CLIENT'S CURRENT SITUATION

Living Arrangements: ☐ Immediate Family ☐ With Parents

☐ Alone ☐ With Extended Family ☐ With Children ☐ With Friends

☐ Other: (Shelter, Detox, Transition House, Homeless, Recovery Home)

_____

Are the people the client is living with using alcohol and/or drugs?

☐ Yes ☐ No

Is the client expected to return to this home/residence?

☐ Yes ☐ No

If no, identify new living arrangements

_____

MARITAL STATUS

☐ Single ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated

Separation Date: _____ Other: _____

LEGAL MATTERS

Does the client have outstanding charges: ☐ Yes ☐ No

Indicate upcoming Court Date, if applicable: _____

☐ Family Court ☐ Criminal Court

If yes, please provide a good copy of the Order.

Is Treatment a Condition of the order? ☐ Yes ☐ No

Details:

_____

_____

_____

Is the client currently on: ☐ Bail ☐ Parole ☐ Probation

☐ Other:

_____

Details:

_____

_____

_____

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If the client is on probation, please provide name, agency, and contact information:

_____

_____

Does the client have legal representation? ☐ Yes ☐ No

If yes, please provide the name, agency/firm, and contact information:

_____

_____

Does the client have any past legal issues that may be pertinent or they would like the 2nd Floor Women's Recovery Centre to be aware of?

If yes, please provide details:

_____

_____

_____

_____

CLIENT EDUCATION

Highest Level of Education Completed: _____

Trade/Technical Courses/Other Achievements:

_____

_____

_____

_____

English Language spoken by the client: ☐ Yes ☐ No Written: ☐ Yes ☐ No

Other Language spoken by the client: ☐ Yes ☐ No

Please list languages: _____

Literacy Skills- Do you require assistance for reading and writing?
☐ Yes ☐ No

Other Educational Related Information:

_____

_____

_____

_____

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CLIENT'S SOURCE OF INCOME

☐ E.I.: ☐ AISH: ☐ SFI: ☐ Employment:

☐ Other: _____

EMPLOYMENT

☐ Employed ☐ Unemployed ☐ Retired ☐ Job Training ☐ Student

Date of most recent employment: _____

Position: _____

Where: _____

Length of Employment: _____

CLIENT'S CHILDREN (*please use additional sheet of paper if necessary*)

1. Child's Name: _____

Date of Birth: _____ Gender: _____

Child Resides With:_____

2. Child's Name:_____

Date of Birth: _____ Gender: _____

Child Resides With:_____

3. Child's Name:_____

Date of Birth: _____ Gender: _____

Child Resides With:_____

Is Child & Family Services involved with the client's immediate family? ☐ Yes ☐ No

_____

_____

Are any other service agencies involved with the client's immediate family? ☐ Yes ☐ No

_____

_____

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Are there conditions we need to be aware of? ☐ Yes ☐ No

If yes, Please provide details:

_____
_____
_____
_____

ADDITIONAL INFORMATION

Are there any Vision/Dental needs? ☐ Yes ☐ No

If yes, please describe:

_____
_____
_____

List skills, hobbies, interests, strengths, and accomplishments the client enjoys or is proud of:

_____
_____
_____
_____

Are there any issues or concerns that the client has regarding treatment at the 2nd Floor Women's Recovery Centre?

_____
_____
_____

We, the undersigned, agree that the information provided on this Referral Form is true and accurate to the best of our ability.

Signature of Worker: _____

Date: _____

Signature of Client: _____

Date: _____

Please send completed Referral Package to:

admin@lcfasd.com

OR

Fax to confidential line @ 1.780.594.9907

OR

Mail to P.O. Box 479 Cold Lake, AB T9M 1P1

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