

**NORTH BAY RECOVERY HOME APPLICATION FORM (PAGE 1 OF 4)**

**Catalyst#:** \_\_\_\_\_ **Referred:** dd \_\_\_\_\_ mm \_\_\_\_\_ yyyy \_\_\_\_\_

**NBRH File:** \_\_\_\_\_ **Referred:** dd \_\_\_\_\_ mm \_\_\_\_\_ yyyy \_\_\_\_\_

**Client Information:**

**First Name:** \_\_\_\_\_ **Middle Name:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **Last Name at Birth:** \_\_\_\_\_

**Alternate:** \_\_\_\_\_ **D.O.B:** dd \_\_\_\_\_ mm \_\_\_\_\_ yyyy \_\_\_\_\_ **Age:** \_\_\_\_\_

**Gender:**  Male  Female **Health Card #:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Province:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Country:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ OK to call:  Y  N OK to leave a message:  Y  N

**Cell Phone:** \_\_\_\_\_ OK to call:  Y  N OK to leave a message:  Y  N

**Other Phone:** \_\_\_\_\_ OK to call:  Y  N OK to leave a message:  Y  N

**Current Location** (if different from above) \_\_\_\_\_

**Phone:** \_\_\_\_\_ OK to call:  Y  N OK to leave a message:  Y  N

**Emergency Contact:** \_\_\_\_\_

**Relation:** \_\_\_\_\_ **Emergency Phone:** \_\_\_\_\_

**Preferred Language:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Referral Information:**

**Referred:** dd \_\_\_\_\_ mm \_\_\_\_\_ yyyy \_\_\_\_\_ **Referring Source:** \_\_\_\_\_

**Referring Agency:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Are ADAT/GAINS Q3 tools completed?**  Y  N  In the Process

(If yes ask to receive Tracking Summary and Health Screening Form)



## NORTH BAY RECOVERY HOME APPLICATION FORM (PAGE 2 OF 4)

### Legal Issues:

**Treatment Mandated/Required by:** \_\_\_\_\_

**Legal status:** \_\_\_\_\_

**Probation Start:** dd \_\_\_\_ mm \_\_\_\_ yyyy \_\_\_\_ **Probation End:** dd \_\_\_\_ mm \_\_\_\_ yyyy \_\_\_\_

**Charges Pending:** \_\_\_\_\_

**Legal History:** \_\_\_\_\_

**Relationship Status:** \_\_\_\_\_ **Education:** \_\_\_\_\_

**Children:**  Y  N **Employment Status:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Income Source:**  ODSP  Disability Insurance  Ontario Works  Employment  
 None  Retirement Income  Employment Insurance

**Date of Last Checque Received:** dd \_\_\_\_ mm \_\_\_\_ yyyy \_\_\_\_ **Amount:** \$ \_\_\_\_\_

### Substance Use:

**Presenting Problem Substances (Drugs of Choice) 1. Did not use 2. 1-3 times monthly  
3. 1-2 times weekly 4. 3-6 times weekly 5. Daily 6. Binge 7. Unknown**

1. \_\_\_\_\_ Frequency in last 30 days: \_\_\_\_\_

2. \_\_\_\_\_ Frequency in last 30 days: \_\_\_\_\_

3. \_\_\_\_\_ Frequency in last 30 days: \_\_\_\_\_

4. \_\_\_\_\_ Frequency in last 30 days: \_\_\_\_\_

5. \_\_\_\_\_ Frequency in last 30 days: \_\_\_\_\_

**Substances used in the past 12 months:** \_\_\_\_\_

**Gambling:**  Y  N  Unkown

**Last Date Substance Used:** dd \_\_\_\_ mm \_\_\_\_ yyyy \_\_\_\_ **Substance:** \_\_\_\_\_

**Previous Treatment:**  Y  N If yes, when and where: \_\_\_\_\_

**Recovery Homes:**  Y  N If yes, when and where: \_\_\_\_\_



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### Health Status/Problems:

**Visual Impairment:**  Y  N  Unkown **Hearing Impairment:**  Y  N  Unkown

**Mobility Impairment:**  Y  N  Unkown **Pregnant:**  Y  N  Unkown  N/A

**Non medical injection use:**  Never  Prior to 1 year  Past 12 months  Unknown

**Number of overnight Hospitalizations in the last 12 months for physical problems:** \_\_\_\_  Unknown

**Reason for most recent Hospitalization:** \_\_\_\_\_

### Diagnosed with a Mental Health problem by a qualified Mental Health Professional?

Within the last 12 months:  Y  N  Unkown Within lifetime:  Y  N  Unkown

Most Recent Diagnosis #1: \_\_\_\_\_ Most Recent Diagnosis #2: \_\_\_\_\_

### Hospitalized for a Mental Health problem?

Within the last 12 months:  Y  N  Unkown Within lifetime:  Y  N  Unkown

### Received treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

Currently:  Y  N  Unkown Within the last 12 months:  Y  N  Unkown

Within lifetime:  Y  N  Unkown

Name of service provider: \_\_\_\_\_ Phone: \_\_\_\_\_

### Prescribed medication for a mental health problem?

Currently:  Y  N  Unkown Within the last 12 months:  Y  N  Unkown

Within lifetime:  Y  N  Unkown

Name and dosage of medication: \_\_\_\_\_

**Primary health care provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Health Conditions/Problems/Allergies:** \_\_\_\_\_

**Methadone/Suboxone:**  Y  N  Unkown

**Have you ever had a transmittable illness/disease:**  Y  N  Unkown

If yes, what: \_\_\_\_\_



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**Current Medications:**

**Name:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Purpose:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Purpose:** \_\_\_\_\_

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.  
• I understand that there are some circumstances in which this information may be re-disclosed to other parties and no longer protected by federal privacy laws. • I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission. • I have read all pages of this form and agree to the disclosures above from the types of sources listed.

**Signed this** \_\_\_\_\_ **Day of** \_\_\_\_\_ **, 20** \_\_\_\_\_

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**Printed name of applicant**

**Signature of applicant**

**Additional Information:**

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