



# CENTRE WANAKI CENTRE

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ADMISSIONS: ext 4227  
☎ 819-449-2007  
✉ admissions@wanakicentre.com

## WANAKI CENTRE ADMISSION FORM

The Wanaki Treatment Center is as an accredited specialized bilingual resource center by the National Native Alcohol and Drug Abuse Program (NNADAP), the Center offers a 4-week in-person program and a 4-week virtual program on a rotational basis in both languages, English and French. All applications are subject to a review based on the established criteria in order to inform the final admission decision. Priority will be given to individuals that are members of one of the nine Algonquin First Nation communities.

### Admission criteria to be assessed

- The Wanaki Center application must be fully completed and submit.
- Must be recognized and have status as a member of a First Nation or as a member of an Inuit community in Canada.
- A current medical card from one the provinces or territories in Canada.
- Must be 18 years or older. Please note that the Wanaki Center may consider an applicant who is 17 years of age if the applicant has a written parental consent.
- People must be willing to work on their personal healing and recovery.

### In-person program specific admission criteria

- Court dates and other appointments (such as with lawyers, probation or parole officers, youth protection representatives etc...) should be arranged prior or after treatment period.
- Must have completed a medical exam with a doctor and/or nurse indicating a state of physical and mental health capable of undergoing a treatment program.
- These criteria cannot participate in the in-person program but can participate in the virtual program:
  - Any person on a Methadone or Suboxone.
  - Pregnant women 20 weeks or more.
  - Immediate relationships, such as sibling, parent-child, couple.

### Virtual program specific admission criteria

- No specific criteria apply to the virtual program.

### Program admission selection

*Facilitating the admission process, a participant interested in both programs and/or is bilingual can simply fill out one application form and be eligible for either program in either language. We will prioritize preferences when assessing the file. Multiple choices can be selected.*

Program Selection	Order of Preference
<input type="checkbox"/> In-person	1. _____
<input type="checkbox"/> Virtual	2. _____

Language Preference	Order of Preference
<input type="checkbox"/> English	1. _____
<input type="checkbox"/> French	2. _____



📍 @centrewanakicentre 📱 @wanakicentre 🐦 @WanakiCentre

*30 years of empowering First Nations and Inuit Peoples to live a balanced lifestyle.  
30 ans de parcours de guérison culturelle de qualité offert aux Premières Nations et Inuits.*



## ADMISSION REQUEST WANAKI PROGRAM

Approved December 4, 2024

This admission form contains four (4) sections:

**Section 1:** Informed Consent

**Section 2:** Applicant Admission/General Information

**Section 3:** To be completed by the applicant

**Section 4:** Health Evaluation

- STEP 1:** The Wanaki Centre must receive sections 1 to 4 fully completed before we can proceed with our clinical assessment. We highly recommend to all applicants to have a referral worker for support.
- STEP 2:** The Centre will complete a clinical assessment. The Centre's admission decision will be provided to the referral and applicant.
- STEP 3:** Upon receipt of the admission decision, the referral and applicant must sign and return the signed form by fax or email to confirm the applicant's admission to the program cycle.
- STEP 4:** Once the Wanaki Centre has received the signed admission decision form by the applicant and referral worker, a Zoom or phone pre-contact meeting will be scheduled with the applicant prior to the start of the program to provide additional information.

**There are 5 principles to follow:**

### **In-person**

- No possession or consumption of alcohol or drugs during the treatment
- No violence of any kind
- Must adhere to the structure rules and regulations from the beginning to the end of the Program
- No intimate contact
- No smoking inside the building or outdoor structures

### **Virtual**

- Respect for yourself and others
- Honesty with yourself and others
- Willingness to listen and learn
- Openness to share
- Must adhere to the structure rules and regulations from the beginning to the end of the cycle

When applications exceed a period of 3 months from the time of receipt, a new application will have to be re-submitted.

**You are responsible to work to the best of your ability on your 4 aspects:**

- Physical (walking, exercise)
- Mental (paying attention during workshops, reading, learning from others)
- Spiritual (smudging, praying, meditation, offering tobacco)
- Emotional (writing in my journal, sharing in the circle)



## SECTION 1: INFORMED CONSENT

### Informed Consent Form

Wanaki is a recognized NNADAP Treatment Centre with over 30 years of experience specializing in substance abuse programming. We value our relationship with our participants and believe that such relationship is the guide in the healing process.

We believe that everyone is unique and has their own way of addressing resolutions. This, we believe in a wellness model that helps our participants empower themselves by focusing on what works for them and not in a systematic approach that provides a generic procedure on working on a treatment. One's journey is not the same as the other.

### Applicant's Rights

1. The applicant may ask questions on what to expect during the treatment program.
2. The applicant may cease the treatment application at any time.
3. The applicant has the right to inquire about their application status.
4. Right to confidentiality: Within limits provided for by law, all records and information acquired by the Wanaki center will be kept confidential in accordance with information management principles. All information will not be shared or revealed to any person, agency, or organization without the prior written consent of the applicant.

### Emergency Contact Consent

For safety measures we require that you provide 2 (two) emergency contacts. Your consent is required for Wanaki centre in case of emergency.

- I understand that by writing my emergency contacts, I authorize the Wanaki Center to contact them in case of emergency.**

Emergency Contact #1	Emergency Contact #2
Name:	Name:
Phone number:	Phone number:
Relationship:	Relationship:

I \_\_\_\_\_, declare that I have read all the information including my responsibilities. I understand that if I do not abide by the outlined principles and responsibilities that I could be asked to leave the program. I agree that if I am accepted in the program that I will fully participate on a daily basis, and complete work assignments.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date (D/M/Y)

\_\_\_\_\_  
Referral Signature

\_\_\_\_\_  
Date (D/M/Y)



## SECTION 2: APPLICANT ADMISSION – GENERAL INFORMATION

**\*\* Please include a copy of provincial health and the first nation status card or Inuit registration**

*Surname:		*Name:	
Email:		Health card number:	exp. Date:
*Date of birth DD/MM/YYYY:	Age:	*Gender (identify as):	Telephone:
		Cellphone:	
*Address (Add P.O box if required)		City:	Province:
		Postal Code:	
Language Spoken:		Language Preferred:	Language Understood:
Community:		Nation:	First Nation status number / Inuit registration:

### EDUCATION

Last grade completed? _____ <input type="checkbox"/> Elementary school <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> University <input type="checkbox"/> Professional <input type="checkbox"/> Other:	Where? <input type="checkbox"/> Public Off-Reserve <input type="checkbox"/> Public On-Reserve <input type="checkbox"/> Private School <input type="checkbox"/> Residential School	Reading Level: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor	Writing Level: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor
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### FINANCIAL SITUATION

Employment status / Financial situation:	What has been your principal source of income during the past six months?  <input type="checkbox"/> Work <input type="checkbox"/> Employment Insurance <input type="checkbox"/> Spouse <input type="checkbox"/> Pension or Insurance <input type="checkbox"/> Parents <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Social Assistance
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### FAMILY / RELATIONSHIPS

Marial Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Does applicant have dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____	If yes, do they have access to adequate childcare while in the program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Are the children in care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Does the applicant have other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Provide information on the applicant's children or other dependents:

Name	Age	Relationship

Family Support:	Family Strengths:
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**\*\*PLEASE READ CAREFULLY\*\***

If you have any legal situations, you will have to meet the following criteria.

Provide any supporting documentation requested by Wanaki to complete a proper assessment of the application. Referral workers will need to provide Wanaki with a written confirmation from the court that the applicant will not have any court appearances, probationary conditions or parole conditions that would interrupt the applicant's treatment services for 4 weeks. If the person applying has an active criminal record, a copy of this record will need to be forwarded to us to complete the application.

**In-person program only:** The detention centre or community will have to ensure that the applicant arrives at Wanaki Center with the transportation and means to return home or to the detention center where they are from. If a applicant arrives with legal conditions on intake day without return transportation means they will not be accepted.

**LEGAL STATUS**

Has the applicant been court ordered to attend the program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details (include details/copy of Probation Order if applicable and/or available)	Is the applicant under any of the following legal condition? <input type="checkbox"/> Bail <input type="checkbox"/> Parole <input type="checkbox"/> Temporary Absence Order
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Legal System Involvement: <input type="checkbox"/> Criminal Court <input type="checkbox"/> Court Order <input type="checkbox"/> Family Court <input type="checkbox"/> Restorative Justice <input type="checkbox"/> Drug Court Treatment <input type="checkbox"/> Pre-trial Release <input type="checkbox"/> Probation <input type="checkbox"/> Conditional Sentence <input type="checkbox"/> Charges Pending	Other (provide details, dates, etc.): <b>*MANDATORY</b> to provide criminal records information
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**HISTORY**

Has applicant participated in a non-residential / community-based substance abuse program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the applicant participated in a non-residential / community-based mental health program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the applicant participated in a residential / virtual treatment program before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____
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If yes, please provide information on previous treatment experience:

Year	Treatment Centre	Type of Addiction	Completed	Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Reason(s) for currently requesting to join a program?



CONSUMPTION																															
What age were you when you first started consuming substances?		What age were you when you first started began having serious substance abuse issues?																													
On average how often do you consume substances?																															
<input type="checkbox"/> Everyday <input type="checkbox"/> Weekends <input type="checkbox"/> Few days a week <input type="checkbox"/> 1-2 days a month																															
What type(s) of substance do you abuse?																															
<table border="0"> <tr> <td>Alcohol:</td> <td>Drugs:</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Beer</td> <td><input type="checkbox"/> Weed</td> <td><input type="checkbox"/> Heroin</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Liquor</td> <td><input type="checkbox"/> Cocaine</td> <td><input type="checkbox"/> P.C.P</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Wine</td> <td><input type="checkbox"/> Speed</td> <td><input type="checkbox"/> Acid</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> Ecstasy</td> <td><input type="checkbox"/> Mescaline</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Crystal Meth</td> <td><input type="checkbox"/> Solvent/Inhalants</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Opioids</td> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>				Alcohol:	Drugs:			<input type="checkbox"/> Beer	<input type="checkbox"/> Weed	<input type="checkbox"/> Heroin		<input type="checkbox"/> Liquor	<input type="checkbox"/> Cocaine	<input type="checkbox"/> P.C.P		<input type="checkbox"/> Wine	<input type="checkbox"/> Speed	<input type="checkbox"/> Acid		<input type="checkbox"/> Other: _____	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Mescaline			<input type="checkbox"/> Crystal Meth	<input type="checkbox"/> Solvent/Inhalants			<input type="checkbox"/> Opioids	<input type="checkbox"/> Other: _____	
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	<input type="checkbox"/> Crystal Meth	<input type="checkbox"/> Solvent/Inhalants																													
	<input type="checkbox"/> Opioids	<input type="checkbox"/> Other: _____																													
Abuse Prescription drugs:		Nicotine:																													
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____		<input type="checkbox"/> Shewing tobacco <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Vapes <input type="checkbox"/> Other: _____ <input type="checkbox"/> Cigars																													
Sober since (if applicable):																															
Why do you think you use substances?																															



<b>WITHDRAWAL SYMPTOMS</b>		
Has applicant experienced any of the following symptoms while withdrawing from substances <b>in the last 12 months?</b>		
Symptom		Describe
Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Shakes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Delirium Tremens (DT's)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Ever experienced DT's?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PROCESS BEHAVIOURAL ADDICTION</b>		
Has applicant experienced problems with any of the following <b>in the past 12 months?</b>		
Process/Behavioural Addiction		Describe
Gambling (slots, cards, Keno, bingo, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Eating (obesity, anorexia, bulimia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Sex (promiscuity, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Cellphone/texting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Social media	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Gaming	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Other (please specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	



<b>MENTAL HEALTH</b>		
Provide the following information about the applicant's health status <b>in the past 12 months:</b>		
Mental Illness		Describe
Been diagnosed with a mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	If yes, please explain:
Currently being treated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Currently on psychiatric medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	If yes, please list medication:
Taking medication consistently	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
*Previous suicide attempts/ideation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	If yes, when?
*Hospitalized for suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	If yes, when?
*Currently suicidal	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	
Other important information:		Name and phone number of psychiatrist/psychologist (if applicable)
<b>OTHER</b>		
What spiritual/religious beliefs do you follow?		Are you interested in learning basic Algonquin First Nation Cultural and Spiritual teachings? (Please take note, this is part of the program) <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the applicant have cultural and/or spiritual beliefs and practices we need to be aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:
Does applicant have literacy or learning needs or issues we need to be aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:
Are there any other significant issues we need to be aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:
Does applicant understand there is an expectation they have been alcohol and drug free for at least 7 days prior to admission (or 14 days if withdrawing from benzodiazepines). (Applicant with less than the required days must notify Wanaki Centre prior to admission).		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal strengths:		





REFERRAL INFORMATION					
Surname:			Name:		
Employment title:		Telephone:		Cellphone:	
Organization:			Email:		
Organisation address:(Add P.O box if required)			City:	Province:	Postal Code:
Has the applicant completed two pre-program appointments?  <input type="checkbox"/> Yes <input type="checkbox"/> No			Will you continue to see the applicant once he/she has completed the program?  <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please provide appointment dates	Date 1:	Date 2:	Date 3:	Date:	
What other supports would be available to your applicant in their community upon completion of treatment?					
Name/Resource		Description of support			
Please provide/attach a brief assessment summary (Assessment Summaries completed within 6 weeks of this application may be substituted and attached) including summarization of any assessment processes completed with the applicant (e.g., SASSI, MAST, DAST, etc.) which support the application to the program and evaluate how addictions have affected your applicant in all domains (e.g., domestic, medical, school, psychological, spiritual, emotional).					
APPLICANT'S STAGE OF READINESS					
<input type="checkbox"/> Precontemplation - Not considering change; resistant to change. <input type="checkbox"/> Contemplation - Unsure of whether or not to change, chronic indecision. <input type="checkbox"/> Determination - Preparation; committed to changing behaviour within one month. <input type="checkbox"/> Action - Begin changing behaviour. <input type="checkbox"/> Maintenance - Behaviour change has persisted for 6 months or more.					
Please list any questions or concerns the applicant has indicated during the intake process:					
What other areas might need to be addressed in the program? (e.g., abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):					
Referral assessment of the applicant's strengths and potential challenges for completing the program:					



REFERRAL CHECKLIST		
Please initial which applicable items have been completed. Check off any items attached to this application:		
Item	Attached	Initials
Psychiatric Evaluations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Probation Order	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Medical Assessment Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assessment Summary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Profile	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please note, as a general reminder for your applicant that individual from same communities can apply and attend the same program at the same time	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please Initial each item that has been completed:		
Item	Initials	
All medical, dental, and optical appointments have been dealt with prior treatment.		
All financial matters have been dealt with prior treatment.		
All legal matters have been dealt with prior treatment.		
REFERRAL ASSESSMENT		
Do you think your applicant needs detox before starting our program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain more:
REQUIRED EQUIPMENT CHECK FOR VIRTUAL PROGRAM ONLY (IF APPLICABLE)		
Does the client have an appropriate device with a camera and microphone to participate in the program? (E.g., Smartphone, tablet, laptop, computer, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered no, are you able to provide your client with a device or location with a device in order to participate in the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered no, Wanaki offers the rental of tablets with data for clients who need them for the duration of the program. Does your client need a tablet from the Wanaki center?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please note that when you request a tablet rental from us, you automatically become responsible for the tablet provided to your client and a contract to be signed will be sent to you. <b>Tablet rental can be done by a referent only.</b>		
SIGNATURE		
Referral Signature	Date (D/M/Y)	





## SECTION 4: MEDICAL EVALUATION

PHYSICIAN/NURSE INFORMATION			
Surname:		Name:	
Employment title:	Telephone:	Cellphone:	
Organization:		Email:	
Organisation address:(Add P.O box if required)		City:	Province: Postal Code:
Applicant's surname:		Applicant's name:	

IF YOU ARE APPLYING TO THE VIRTUAL PROGRAM ONLY, PLEASE COMPLETE PARTS 1-2 AND 4			
PART 1: DOES THE PERSON HAVE THE FOLLOWING CONDITIONS, AS DIAGNOSED BY A PHYSICIAN?			
CHECK OFF ALL THAT APPLY			
<input type="checkbox"/> Pregnancy <b>*Please take note that the Wanaki Centre does not accept women passed 20 weeks within the in-person program*</b>	Number of weeks?	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last medical exam?
	Other comments (e.g., date of next medical appointment, number of previous pregnancies, voluntary termination of pregnancy, high risk pregnancy etc.):		
<input type="checkbox"/> Cardiac Disorders (including hypertension, low blood pressure, angina)	Date of last episode?	Please specify which cardiac disorder:	Last medical exam?
	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you awaiting surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other comments (ex; date of next appointment, family history, etc.)		
<input type="checkbox"/> Epilepsy	Date of last episode?	Last medical exam?	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other comments (ex; date of next appointment, etc.):		
<input type="checkbox"/> Hepatic Disorder (e.g.: Cirrhosis, jaundice, hepatitis A, B,C, liver problem, edema)	Date of last episode?	Please specify which hepatic disorder:	Last medical exam?
			Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other comments (ex. date of next appointment etc.)			



<input type="checkbox"/> Diabetes	Last medical exam?	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your diabetes stable? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you taking insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you follow a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your last blood test (A1C result)?
	Other comments (ex. date of next appointment etc.)		
<input type="checkbox"/> Recent history (1 month) of head trauma with loss of consciousness (ex: fractured skull)	Date of event?	Last medical exam?	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other comments (ex: date of next appointment, etc.):		
<input type="checkbox"/> Respiratory disorders (Asthma, chronic bronchitis, emphysema, infections, cough)	Please specify which respiratory disorder:		Do you have a cough? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, characteristics of expectoration?
	Date of last episode?	Last medical exam?	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other comments (ex: date of next appointment, specialists, etc.):		
<input type="checkbox"/> Allergy (drugs, food, others)	Please specify allergies.		Types of reactions? (rash, hives, anaphylactic etc.)
	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	EpiPen? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other comments (ex: date of next appointment, specialists, etc.):		
<input type="checkbox"/> Mental health disorders (Anxiety, depression, psychosis, schizophrenia etc.)	Please specify:		
<input type="checkbox"/> Other (Ex: STBBI, HIV, Inflammations, infections, condition of injection sites and all other wounds, mobility problems, unstable/undiagnosed issues, significant weight gain/loss)	Please specify:	Last medical exam?	Are you followed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other comments (ex: date of next appointment)		
<b>PART 2: PHYSICAL EXAM</b>			
Blood pressure:	Heart rate:	Respiration:	Temperature:
Weight:	Height:	Blood Glucose:	Wounds:
Do you suggest any additional medical exam, tests, or investigations prior to the applicant's admission to the Wanaki?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify:	
In your opinion, does your applicant require substance abuse detoxification prior to entering the Wanaki in-person program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:	
Do you have a family doctor or Nurse on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, first and last name of medical professional:	
		Clinic Name:	
		Phone Number:	City:



**PART 3: WANAKI TUBERCULOSIS SYMPTOM SCREENING QUESTIONNAIRE (IN-PERSON ONLY)**  
 Part A should be answered by the applicant. A healthcare professional must evaluate the answers and assign a recommendation in Part B. Please note that a **TB skin test is not mandatory** for entry to the Wanaki Centre. If the applicant answers YES to more than one question, we recommend further investigation prior to admission to the Wanaki Centre.

PART A		
A productive cough for more than 3 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemoptysis (coughing up blood)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever, Chills, or night sweats for no known reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Persistent shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had contact with anyone with active tuberculosis in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your community currently have tuberculosis cases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had a TB skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes to a TB test	Date:	Result:

PART B		
Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:		
<input type="checkbox"/> There is no indication this person has active tuberculosis at this time.		
<input type="checkbox"/> Further evaluation, including a TB Skin Test or other medical evaluation is indicated, and should be completed prior to admission to a facility.		
Health Professional signature	Printed name	Date

PART 4: MEDICATION		
<b>**PLEASE READ CAREFULLY**</b>		
We prefer a pharmacy printout of the participants' medication record. <b>In-person program:</b> We also ask that the applicant arrive at the Centre with 4 weeks of their medication already prepared in DOSETTES (blister packaging from pharmacy) if not available, we ask that they show up with no more than 3 days' worth of medication. Do not bring any medications not prescribed; it will be disposed of. Same thing with powder protein supplements. We optimize healthy eating, which provides all the nutrients the body needs.		
<b>Is your applicant taking any prescribed medication currently? (If yes, please specify name, dosage, duration, and any special recommendations for use or attach pharmacy list)</b>		
Name of medication	Reason	Psychoactive effect

I have examined \_\_\_\_\_ and find him/her fit to attend the Wanaki Center's program in-person and/or virtual.

Physician or Nurse's Verification Stamp

\_\_\_\_\_  
 Physician or Registered Nurse's Signature

\_\_\_\_\_  
 Date DD/MM/YYYY

