



SAGASHTAWAO HEALING LODGE

REFERRAL FORM

Please check one of the programs below:

- APersonal Life Review@ Three-week Relapse Prevention Program**
- AI Have Hope In My Life@ Six-week Treatment Program**

GENERAL INFORMATION

Last Name: _____ First Name: _____

Sex: Male Female Date of Birth: _____

Social Insurance Number: _____ - _____ - _____ Health Number: _____

Mailing Address: _____

Street Address: _____

Postal Code: _____ Telephone Number: (____) _____ - _____

Status Indian: Yes No Living on Reserve: Yes No

If yes, How long? _____

Name of Band: _____ Band Number: _____

Spiritual Beliefs: Traditional Roman Catholic Anglican Pentecostal Other

Language (s) spoken by client: English Cree Ojibway Other

Language (s) client reads: English Cree Ojibway Other

Language (s) client writes: English Cree Ojibway Other

IN CASE OF EMERGENCY

Next of Kin: _____

Address: _____

**SAGASHTAWAO HEALING LODGE
REFERRAL FORM**

-3-

LEGAL STATUS

Parole Current Parole condition: _____

Probation Current Probation condition: _____

Incarcerated Release date: _____

Court/Legal Action Pending Yes No Court
Date: _____

Current Charges: _____

Outstanding charges: _____

Prior Charges: _____

EDUCATION BACKGROUND

Please state your level and/ or grade of completion beside all that apply to you.

Elementary (grade completed) _____ High School (grade completed) _____

College diploma (program course)

University degree(program course)

Other Courses: _____

EMPLOYMENT

Part-time Homemaker Self-Employed Job Training

Employed Unemployed Seasonal Retired

Temporary Student E.I. Other: _____

INCOME SOURCE:

- Job Income Assistance Family E.I.
 None Other: _____

LIST SKILLS, HOBBIES, AND INTERESTS :

**SAGASHTAWAO HEALING LODGE
REFERRAL FORM**

-4-

PREVIOUS SUBSTANCE ABUSE HISTORY (please fill in this information)

Alcohol/Drugs	Age First Used d/m/y	Date Last Used d/m/y
example: Cocaine	I was 15yrs old	I last used on July 25, 2003

PREVIOUS TREATMENT FOR ALCOHOL AND DRUG ABUSE (list two most recent)

1) Name of Facility: _____

Date Admitted: _____ Date Completed: _____

Type of Treatment: _____ Length of Treatment: _____

Duration of Abstinence Following Treatment: _____

2) Name of Facility: _____

Date Admitted: _____ Date Completed: _____

Type of Treatment: _____ Length of Treatment: _____

Duration of Abstinence Following Treatment: _____

I AUTHORIZE Sagashtawao Healing Lodge to inquire for verification regarding my previous treatment history.

Signature of client

Date

Witness (Worker/Counselor)

Date

SAGASHTAWAO HEALING LODGE
REFERRAL FORM

-5-

ADDITIONAL INFORMATION

Presenting problems for which client now seeks help.

Any issues/concerns client has regarding treatment at the Healing Lodge.

REFERRAL AGENCY

Referral Worker: _____

Referral Agency: _____

Address: _____

Postal Code: _____

Phone Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

Any recommendations by Referral Worker: _____

Will aftercare/follow-up plans be made between client and worker? Please comment.

Referrals= Signature: _____ Date: _____

Clients= Signature: _____ Date: _____

PLEASE ENSURE COMPLETED MEDICAL FORM IS ATTACHED TO
YOUR REFERRAL FORM BEFORE FAXING TO (705) 336-3452
OR MAILING TO: P.O. BOX 99, MOOSONEE, ONTARIO P0L 1Y0

Revised 08, 2005