STONEHENGE Therapeutic Community

APPLICATION FOR RESIDENTIAL TREATMENT

Instructions: The following form is required to begin the application process to Stonehenge. The form should be printed and completed by hand, then faxed or mailed to Stonehenge (info below). If you already have an Assessment appointment booked, you can bring the completed form on that day, instead of sending it ahead of time. To schedule an Assessment appointment, please contact the Stonehenge Reception office at (519) 837-1470, Ext. 0

Mailing Address: Stonehenge Therapeutic Community, c/o Admissions, 60 Westwood Road, Guelph, Ontario N1H 7X3
Fax Number: Completed applications can be faxed to (519) 837-3232. Please mark with 'Attention: Admissions'.
Admission Coordinator Phone Extensions: Women's Residential Program – 226; Men's Residential Program – 227.
Website: Detailed information on our programs and the assessment process can be found at www.stonehengetc.com.

OFFICE USE ONLY	
Referred On:	
Status:	☐ Health ☐ Provincial Corrections ☐ Federal Corrections ☐ Fee-for-Service

START HERE

Date this form was completed:	

Personal Information					
First Name:		Last Name:			
Full name at birth (if different than above):					
If you use an alternate name, please include it:					
Date of Birth:		Gender:			
Do you have a valid Ontario Health Card?	☐ Yes ☐ No	Health Card Number:			
Home Address:		City:		Province:	
Postal Code:		No Fixed Address?	☐ Yes ☐ No		
Current Location (if different than above):					
Phone Number:		Okay to leave a message?	☐ Yes ☐ No		
Name of Emergency Contact:		Relationship:			
Emergency Contact Phone #:		Okay to leave a message?	☐ Yes ☐ No		
Language you prefer to receive service in?					
Ethnicity (e.g. Canadian, First Nations, Irish, etc):					

Referral Information	
Please specify the referring agency(ies):	
Contact Name at referring agency(ies):	
Please check the boxes that explain who referred you to Stonehenge:	

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☐ Self	☐ Day/Evening Addictions	☐ Correctional Facility
☐ Family/Friend	☐ Psychiatric Services	☐ Non-Addictions Residential
☐ Initial Assessment Treatment Planning	☐ Psychiatrist/Psychologist	☐ Self-Help Group
☐ Withdrawal Management Centre	☐ Medical Services	☐ EAP/Employer
☐ Community Withdrawal Management	☐ Community Health Centre	☐ Police
☐ Residential Addictions	☐ Physician/Private Practice	☐ Other Legal
☐ Supportive Housing	☐ Public Health Unit Nurse	☐ DART/Connex website
☐ Outpatient Addictions	☐ Community Mental Health	☐ Other

Employment Status:	☐ (Self) Employed Full-time ☐ Employed Part-time ☐ Unemployed (looking for work) ☐ Student/Re-training	☐ Disability ☐ Not in Labour Force (eg. homemaker) ☐ Retired
Education: (highest level achieved)	☐ No formal schooling ☐ Some Primary School ☐ Completed Primary School ☐ Some Secondary or High School ☐ Completed Secondary or High School	☐ Some College/CEGEP/Nursing ☐ Completed College/CEGEP/Nursing ☐ Some University (not complete ☐ Completed University Degree/Masters/PhD
Income Source:	☐ Disability Insurance ☐ Employment ☐ Employment Insurance (E.I.) ☐ Family Support ☐ None	☐ Ontario Disability (ODSP) ☐ Ontario Works (OW) ☐ Other ☐ Other Insurance (excluding E.I.) ☐ Retirement Income

Previous Substance Treatment

Have you had previous substance treatment?	☐ Yes (if yes, complete chart below)	☐ No	
Treatment Facility / Location	Type of Treatment	Date Attended (mm/yyyy)	Program Length
Have you had previous treatment at Stonehenge?	☐ Yes ☐ No	If yes; when:	

Identified Family

Please identify your current relationship status:	☐ Married ☐ Partnered/Common Law ☐ Single (never married)	☐ Widow/Widower ☐ Divorced/Separated
Birth Place:		

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Please identify your immediate family members below:

Family Member Name	Relationship	Age	Do you have contact with them?	Are they supportive of treatment?	Do they abuse drugs or alcohol?

If you have children, please complete the information below:

Name of Child	Age	Who do they live with?

Are you currently involved with any of the following services (check more than one, if necessary):	☐ Family & Children's Services ☐ First Nations Family Services ☐ Other: _____

Legal Status

FPS#:		OTIS#:	
Are you applying to Stonehenge for Parole?		☐ Yes	☐ No
If yes, please indicate type:		☐ Provincial	☐ Federal - Day Parole ☐ Federal - Full Parole
What is your Parole Eligibility date? (day/month/year)			
If incarcerated, what institution are you currently at?			
Probation / Parole Officer:		Phone:	
Lawyer:		Phone:	

Legal Status:	☐ No Problems ☐ Awaiting Trial or Sentencing ☐ On Probation	☐ On Parole ☐ Incarcerated ☐ Other: _____
Treatment Mandated/Required:	☐ None/No Conditions ☐ Choice of Treatment or Incarceration ☐ Condition of Probation/Parole ☐ Family & Children's Services Requirement	☐ Condition of Employment ☐ Condition of Family ☐ Other: _____

Do you currently have Young Offender status?	☐ Yes	☐ No
Do you have any charges, fines or warrants outstanding or pending?	☐ Yes	☐ No

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If yes, please explain:	
Please list any upcoming court dates:	
Are you currently participating in a Drug Treatment Court program?	☐ Yes ☐ No
If yes, please provide your Drug Treatment Court worker's name:	
Contact Phone #:	Permission to contact? ☐ Yes ☐ No

Please list all prior Convictions	Year	Sentence	Juvenile	Adult
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Physical Health Status

Family Doctor Name (if applicable):	Doctor's Phone Number:
Please check any health issues that apply to you:	

☐ Visual Impairment
☐ Hearing Impairment
☐ Mobility Concerns
☐ Pregnant
☐ Communicable Diseases (eg. Hepatitis, HIV)
☐ Acquired Brain Injury

Please describe your physical health concerns:	
Please list any allergies you have:	
Please indicate the number of <u>overnight hospitalizations</u> in the **last 12 months** for <u>physical problems</u>:	
Please indicate the number of <u>Emergency Department visits</u> in the **last 12 months** for <u>any issue</u>:	
Reason for most recent hospitalization?	
Have you ever injected drugs for non-medical use?	☐ Never injected ☐ Injected within the past year ☐ Injected over a year ago
Have you been diagnosed with a developmental or learning disability?	☐ Yes ☐ No
If yes, please describe:	

Mental Health Status

Have you been <u>diagnosed</u> with a mental health problem by a qualified mental health professional...	
...within the last 12 months?	☐ Yes ☐ No

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	…within your lifetime?	☐ Yes	☐ No
If yes, please explain:			
Have you been hospitalized for a mental health concern within the last 12 months?		☐ Yes	☐ No
Have you been hospitalized for a mental health concern within your lifetime?		☐ Yes	☐ No
Have you received treatment for a mental health, emotional, behavioural or psychological concern from a professional…			
	…currently?	☐ Yes	☐ No
	…within the last 12 months?	☐ Yes	☐ No
	…within your lifetime?	☐ Yes	☐ No
Name of service provider:			
Contact info for service provider:			
Are you prescribed medication for mental health concerns...			
	…currently?	☐ Yes	☐ No
	…within the last 12 months?	☐ Yes	☐ No
	…within your lifetime?	☐ Yes	☐ No

Do you engage in self-harm behaviours (eg. cutting)?	☐ Yes	☐ No	If yes, what?	
Have you ever attempted suicide?	☐ Yes	☐ No	If yes, when?	
Have you ever overdosed?	☐ Yes	☐ No	If yes, when?	

Opioid Substitution

Are you currently participating in an opioid substitution program?	☐ Yes	☐ No
If yes, please indicate which one:	☐ Methadone	☐ Suboxone
If yes, who is your prescriber?		
What is your current dosage?		

Medications

	Please indicate your current medication(s):	Please indicate your current dosage(s):
1		
2		
3		
4		
5		

Current Substance Use

What are your current drugs of choice? Please list in order of severity.	Please indicate below how often you used in the last 30 days for each substance.

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1		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly	☐ 3-6 times weekly ☐ Daily ☐ Binge
2		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly	☐ 3-6 times weekly ☐ Daily ☐ Binge
3		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly	☐ 3-6 times weekly ☐ Daily ☐ Binge
4		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly	☐ 3-6 times weekly ☐ Daily ☐ Binge
5		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly	☐ 3-6 times weekly ☐ Daily ☐ Binge

Please indicate any substances used in the past **12 months** (select all that apply):

Substance	Date Used	Method of Use	
☐ Alcohol		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Amphetamines & other stimulants		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Barbiturates		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Benzodiazepines		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Cannabis		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Cocaine		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Crack		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Ecstasy/MDMA		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Glue/Inhalants		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Hallucinogens		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed

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☐ Heroin/Opium		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Methamphetamines (eg. crystal meth)		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Other psycho-active substances		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Over-the-counter Codeine		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Prescription Opioids		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Steroids		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Tobacco		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Other (please specify)		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
How old were you when you first tried any drug or alcohol?			
How old were you when you first tried your current drug of choice?			

Gambling

Have you ever had gambling identified as a problem?		☐ Yes	☐ No
Would you be interested in treatment for gambling?		☐ Yes	☐ No

Please use the check boxes below to indicate any gambling activities engaged in the past **12 months**:

☐	Bingo	☐	Lottery tickets
☐	Slot machines	☐	Instant win or scratch tickets
☐	Gaming machines (other than slots)	☐	Internet gambling
☐	Casino card or table games	☐	Gambling with stock market or real estate
☐	Non-casino card or table games	☐	Betting on games of skill
☐	Horse races	☐	Betting on outcome of events
☐	Sports betting	☐	Other (please specify):

Thank you for completing the Stonehenge Application Form

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For Office Use Only:	
Has the assessment been completed?	☐ Yes ☐ No
On what date was the assessment completed?	
If no assessment was completed, please indicate why:	
Admissions Staff Name:	
Admissions Staff Signature:	