WOLFE Family Wellness

Working Open-heartedly, Leading Families to Empowerment

Participant Guidelines to WOLFE Family Wellness:

1. This program is completely voluntary to attend and complete. Participants can leave the program at any time to be discharged with no reimbursement.
2. Must be willing to participate in all cultural activities and ceremonies
3. Adult participants must complete detox before beginning programming at WOLFE
5. All travel arrangements must be prearranged; WOLFE does not provide transportation to attend nor upon completion of treatment.
6. Random drug tests will be carried out throughout the program to ensure sobriety
7. Parents/Caregivers are expected to provide the day-to-day care of their children, with staff providing support as necessary.
8. Any drug/alcohol use will not be accepted at WOLFE Family Wellness

Referral Agent:

Referral's Name: _____

Referral Organization: _____

Job Title: _____

Telephone Number: _____

Fax:_____

Email Address: _____

Referral Signature: _____

Date: _____

If participants are non-status, please indicate the person(s)/agency that will be covering costs:

_____

Reason for referral:

Family Strengths: Please identify family strengths (ex. willingness to change, open communication, spirituality, accessing resources, etc.):

Family Goals: Please any intended goals the family would like to achieve as a family unit.

Upon completion of WOLFE: What will the referring worker involvement be with the participant/s?

Children Services: Is there any current involvement with Children Services, if so please state the type of order/legal status

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Please go through the referral package with applicants to ensure they are aware of all program requirements and that the information provided is correct.

INTAKE – Participating Family Information

Adult 1: Male □ Female □ Non-Binary □
First Name: _____ Last Name: _____
Date of Birth: _____
Street Address: _____
Town/City: _____ Province: _____ Postal Code: _____
Status: □ Yes □ No Treaty Number (10 digit): _____
Alberta Health Care Number: _____
Telephone Number: _____
First Nation: _____

Adult 2: Male □ Female □ Non-Binary □
First Name: _____ Last Name: _____
Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: □ Yes □ No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

First Nation: _____

Child 1: Male ☐ Female ☐ Non-Binary ☐

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: ☐ Yes ☐ No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 2: Male ☐ Female ☐ Non-Binary ☐

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: ☐ Yes ☐ No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 3: Male ☐ Female ☐ Non-Binary ☐

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: ☐ Yes ☐ No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 4: Male ☐ Female ☐ Non-Binary ☐

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: ☐ Yes ☐ No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 5: Male ☐ Female ☐ Non-Binary ☐

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: ☐ Yes ☐ No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 6: Male ☐ Female ☐ Non-Binary ☐

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: ☐ Yes ☐ No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Do applicants live on reserve? ☐ Yes ☐ No

Do the applicants and/or children currently practice any cultural traditions ? ☐ Yes ☐ No

If yes, please provide examples.

_____

Do the applicants have any specific cultural teachings they would be interested in participating in? ☐ Yes ☐ No
If Yes, please provide examples

_____

MARITAL INFORMATION IF APPLICABLE

1. How long has the participants been involved in the present marital relationship?

_____

2. Indicate the strengths holding the relationship together and the weaknesses that are causing problems.
Marital Strengths?

_____

Marital Weaknesses?

_____

3. Relationship Breakdown? i.e. Drugs, alcohol, domestic violence, etc.

_____

_____

4. What event(s) took place that caused the participant to seek help at this time? Include details surrounding the event(s).

_____

_____

_____

PARTICIPANT'S PERSPECTIVE/PERCEPTION OF THE PROBLEM – This section is to be completed by the applicant/s

1. Does the participant feel they have a co-dependency problem? ☐ Yes ☐ No
If yes, explain

_____

_____

2. Are Indigenous cultures and values significant for participants' change? ☐ Yes ☐ No
3. Was the participant raised by biological parents? ☐ Yes ☐ No
4. Were there alcohol or drug problems in the family of origin while the participant was growing up (ie. Parents, guardian, sibling)? ☐ Yes ☐ No If yes, explain

5. Major areas affected by substance use (such as employment, friends, and relationships with children). Give details

6. Has the participant previously attended substance abuse programs ☐ Yes ☐ No If yes, provide details, name of the program; date attended; length of intervention; was program completed

7. What has brought you to the decision to apply for programming at WOLFE at this time:

8. Currently, what substance are you seeking treatment for?

9. How long have you struggled with substances?

10. Identify goals you would like to achieve upon completing programming at WOLFE?

11. Please identify all supports: family, friends, professionals, and organizations

Name	Relationship	Telephone Number

See next page for child information.

Child Behaviour Awareness:

Child 1 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self	☐	☐	
Violent outburst	☐	☐	
Challenges with authority	☐	☐	
Cruelty to Animals	☐	☐	
Fire Setting	☐	☐	
Bed wetting	☐	☐	
Inappropriate Sexual Behaviours	☐	☐	
Suicidal Ideations/attempts	☐	☐	
Self-Harm	☐	☐	
Chronic School absences	☐	☐	
Mental Health Diagnosis	☐	☐	
Daily Medication	☐	☐	
Allergies	☐	☐	
Additional Information to be shared	☐	☐	

Child 2 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self	☐	☐	
Violent outburst	☐	☐	
Challenges with authority	☐	☐	
Cruelty to Animals	☐	☐	
Fire Setting	☐	☐	
Bed wetting	☐	☐	
Inappropriate Sexual Behaviours	☐	☐	
Suicidal Ideations/attempts	☐	☐	
Self-Harm	☐	☐	
Chronic School absences	☐	☐	
Mental Health Diagnosis	☐	☐	
Daily Medication	☐	☐	
Allergies	☐	☐	
Additional Information to be shared	☐	☐	

Child 3 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self	☐	☐	
Violent outburst	☐	☐	
Challenges with authority	☐	☐	
Cruelty to Animals	☐	☐	
Fire Setting	☐	☐	
Bed wetting	☐	☐	
Inappropriate Sexual Behaviours	☐	☐	
Suicidal Ideations/attempts	☐	☐	
Self-Harm	☐	☐	
Chronic School absences	☐	☐	
Mental Health Diagnosis	☐	☐	
Daily Medication	☐	☐	
Allergies	☐	☐	
Additional Information to be shared	☐	☐	

Child 4 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self	☐		
Violent outburst	☐	☐	
Challenges with authority	☐	☐	
Cruelty to Animals	☐	☐	
Fire Setting	☐	☐	
Bed wetting	☐	☐	
Inappropriate Sexual Behaviours	☐	☐	
Suicidal Ideations/attempts	☐	☐	
Self-Harm	☐	☐	
Chronic School absences	☐	☐	
Mental Health Diagnosis	☐	☐	
Daily Medication	☐	☐	
Allergies	☐	☐	
Additional Information to be shared	☐	☐	

Child 5 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self	☐	☐	
Violent outburst	☐	☐	
Challenges with authority	☐	☐	
Cruelty to Animals	☐	☐	
Fire Setting	☐	☐	
Bed wetting	☐	☐	
Inappropriate Sexual Behaviours	☐	☐	
Suicidal Ideations/attempts	☐	☐	
Self-Harm	☐	☐	
Chronic School absences	☐	☐	
Mental Health Diagnosis	☐	☐	
Daily Medication	☐	☐	
Allergies	☐	☐	
Additional Information to be shared	☐	☐	

Child 6 name:

Behaviour	YES	NO	Describe
Aggression towards others or self	☐	☐	
Violent outburst	☐	☐	
Challenges with authority	☐	☐	
Cruelty to Animals	☐	☐	
Fire Setting	☐	☐	
Bed wetting	☐	☐	
Inappropriate Sexual Behaviours	☐	☐	
Suicidal Ideations/attempts	☐	☐	
Self-Harm	☐	☐	
Chronic School absences	☐	☐	
Mental Health Diagnosis	☐	☐	
Daily Medication	☐	☐	
Allergies	☐	☐	
Additional Information to be shared	☐	☐	

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MEDICAL ASSESSEMENT

The medical assessment has to be completed by Doctor/Registered Nurse for each family member.

To the Registered Nurse/Doctor:

The aforementioned individual will undergo a medical evaluation as a potential participant in our 90-day residential program for substance use or abuse. Our program is made to help those who admit that their usage or misuse has hampered their ability to work effectively and who are physically and mentally prepared to take part in a rigorous program at WOLFE Family Wellness. The participant listed below should be free of any health issues that would limit their ability to take part in the program.

Participant Personal Information:

Date of Assessment:

_____

First Name: _____Last Name: _____

Birthday (MM/DD/YYYY): _____Age: _____

Gender: Male Female Non-Binary

Alberta Health Care Number: _____

Treaty Number: _____

Please indicate any medical illnesses or diagnoses:

_____

_____

_____

_____

_____

_____

Are there any current or recent medical problems which may or may not require follow-up while the participant is in treatment? Yes: ☐ No: ☐

If yes, please explain:

Please list all current medications for the participant: Name of Medication/ Indication/Duration:

Name of Doctor/RN: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Telephone: _____

Fax: _____

OFFICE STAMP