



## **2<sup>nd</sup> Floor Women's Recovery Centre**

4823-50<sup>th</sup> Street P.O. Box 479

Cold Lake, AB

1.780.594.9903 (p) 1.877.594.5454 (t-f)

1.780.594.9907 (f)

### **TREATMENT REFERRAL PACKAGE**

~Program Information~ ~Referral Forms~

**The 2<sup>nd</sup> Floor Women's Recovery Centre**, operated by **the Lakeland Centre for FASD**, is a unique long term residential treatment program exclusively for women who are using substances and want to make a positive change in their lives. The 2<sup>nd</sup> Floor is a gender responsive program which recognizes that addictions in women are complex across the various roles that a woman plays in society.

Our mission at the 2<sup>nd</sup> Floor is to help women break the cycle of addiction and to reduce the number of babies born prenatally exposed to alcohol and other drugs (AOD) in Alberta. It is estimated that a baby a day is born in Alberta with FASD: FASD is a permanent condition, one that cannot be reversed and often goes without diagnosis.

The 2<sup>nd</sup> Floor is available to women as young as 15 years of age from anywhere in Alberta. A woman may make application anytime throughout her pregnancy, the earlier the better. Minimum treatment period is 28 days to a maximum duration of 7 months. Prior to Admission, each woman will be required to participate in a medically supervised detox of 5-7 days and complete an Admissions Medical with her attending physician.

At the 2<sup>nd</sup> Floor, each woman will have a private room with access to an Addictions Counsellor, Case Manager, Programmer, Registered Nurse, Doctor, other community consultants and service providers. We are unable to provide support or accommodations for client partners or children.

Upon Admission, each client will be seen by our Doctor to provide a medical baseline and prenatal exam. Each client will meet with the Program Staff team to develop an Individual Recovery Program (IRP) which will include one-to-one and/or group sessions with the Addictions Counsellor, Case Manager, Programmer and other services

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as needed. Each IRP will include an Addiction Recovery Plan, Health Plan, Career/Life Management Plan, a Safety Plan and an After Care Plan. Strengths and needs will be identified, such as housing, finances, health, relapse prevention, parenting decisions, and a natural discharge date determined.

Each woman will be transitioned to her home community/community of choice, approximately one month prior to her delivery date, according to her After Care Plan; she will be provided information regarding types of services available in her community, as well as referred to a local PCAP office if available. Self-discharge is a choice of each woman, but it is not recommended.

The 2<sup>nd</sup> Floor employs two primary treatment philosophies: Harm Reduction and Relational Theory. The 2<sup>nd</sup> Floor approach to alcohol and pregnancy is that no alcohol is best when pregnant, planning to become pregnant or nursing. Harm Reduction recognizes that not all women are able to completely abstain from the use of alcohol and other drugs. Women will be provided with information regarding the impact of continued use of Alcohol and other drugs on their person, their fetus, and women will be encouraged to engage in proven preventative measures to prevent future births of children prenatally exposed to alcohol.

A unique aspect of the 2<sup>nd</sup> Floor is that a woman will not necessarily be discharged due to relapse: each situation will be evaluated on an individual basis. Relational Theory speaks to the various roles women play in society and how various experiences and relationships contribute to addiction. The development and support of healthy positive relationships fosters a new direction in women who have chosen to attend the 2<sup>nd</sup> Floor.

Please find attached the **2<sup>nd</sup> Floor Women's Recovery Centre *Client Referral Package***. Please utilize this package only for referrals: it may be completed as a PDF or manually completed. We appreciate your cooperation and effort to assist women in their recovery process.

This package contains program information, referral process and application form, and admittance procedures. Please make copies of this Referral Package for future use.

**Please ensure all areas of the referral forms are completed in full.** Missing information will delay the process. We require:

- ✓ Referral Information Form (Referral Source or SelfReferral);

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- ✓ Pre-Admission Form (signed by client and referring agency);
- ✓ Detox information/Admissions Medical form from supervising physician;
- ✓ Consent to Release of Information;
- ✓ One (1) piece of picture identification or a letter of identification from a professional or service agency before admission to 2<sup>nd</sup> Floor Women's Recovery Centre.

Thank you for considering 2<sup>nd</sup> Floor Women's Recovery Centre. If you have further inquiries regarding our intake procedure, please do not hesitate to call.

**FEES**

The 2<sup>nd</sup> Floor Women's Recovery Centre Fee Schedule is as follows:

- \$40.00/day
  
- Payee will be invoiced by the LCFASD Accounts Manager at month's end;
  
- Self-Pay users will be required to pay the Fee Schedule at the beginning of the month;
  - If a Self-Pay user self-discharges before month's end, fees are *non-refundable*;
  
  - If a Self-Pay user is scheduled to be discharged before month's end, the Fee Schedule will be reduced accordingly;
  
- Fees may be paid in the following manner:
  - Cash
  
  - Certified Cheque

**REFERRAL PROCESS/APPLICATION FOR TREATMENT**

Referrals will be accepted from the following sources:

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- Self-referrals
- Community-based counsellors
- Parent Child Assistance Programs
- Alberta Health Services
  - ☐ Doctor/Addictions/Mental Health/Detox Services
- Women's & Homeless Shelters
- Child & Family Services Case Workers
- Other health-related agencies

**EXCLUSION OF SERVICES**

At this time, the 2<sup>nd</sup> Floor is unable to provide treatment services to women who require:

- Methadone Maintenance
- Prescription Marijuana
- Psychoactive medications but *refuse* to take them
- Accommodations for spouse/partner and/or children

**INTAKE**  
**PROCEDURES**

- Completion/submission of the **Referral Package;**
  - ☐ Including the physician completed **Admission Medical;**
- A telephone interview with the referral worker and/or client;
- Applications will be screened prior to approval;
- Attendance at & completion of a medically supervised detoxification program, due to the inherent risks of detoxing while pregnant, is required. Please advise if assistance from 2<sup>nd</sup> Floor staff is required.

**PRE-TREATMENT CRITERIA**

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Prior to attending the 2<sup>nd</sup> Floor Women's Recovery Centre, clients must:

- Complete a **medically supervised detox program**;
- Complete an **Admissions Medical** which is a comprehensive medical report identifying chronic health issues, sexually transmitted infections and treatments etc to ensure the 2<sup>nd</sup> Floor Consulting Physician is aware of the client's medical concerns & needs;
- Be determined to live a healthier way of life;
- Be able & demonstrate willingness to participate in treatment;
- Review & be willing to abide by the 2<sup>nd</sup> Floor Women's Recovery Centre's program guidelines;
- Take care of any personal/business matters including finances, medical appointments, child care, family, personal relationships and legal issues as the client will not be able to personally tend to these matters for a minimum of one month following admission to the 2<sup>nd</sup> Floor.

The Referral Agency can assist their client in preparing for admission to the 2<sup>nd</sup> Floor Women's Recovery Centre by:

- Reviewing the treatment process with client, familiarize client with alcohol/drug treatment programs, house policies, resident's rights/responsibilities and 2<sup>nd</sup> Floor expectations of the client;
- Assist the client in completing the Referral Package, providing required documentation and funding information;
- Providing information in regards to their client's After Care Plan as part of their Individual Recovery Plan.

**ADMISSION PROCESS**

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- Monday is the usual day for admission the 2<sup>nd</sup> Floor Women's Recovery Centre;
  - ☐ There will be no admissions on weekends;
- Arrival time must be forwarded to intake office not later than 4pm on the Sunday prior to admission;
  - ☐ Any transportation delays must be reported as soon as possible by the worker or client. If we do not receive information of delays, this may result in loss of bed space;
- If a client changes her mind regarding admission, please telephone us as soon as possible to advise of the cancellation;
  - ☐ If a client cancels her admission, her application will be kept on file, but they will need to reapply;
- If a client arrives **without having received acceptance notification**, this client cannot be admitted into the accommodations treatment program. The client will be required to make alternate arrangements and to contact their referral source;

**DRUG & ALCOHOL TESTING**

- Detox Program will be requested to forward the results of the client's Drug & Alcohol tests completed prior to discharge;
- On arrival a Drug Test & Alcohol Swab will be completed;
- Drug & Alcohol tests used at the 2<sup>nd</sup> Floor are Positive or Negative for use;
- If a client tests positive for drugs &/or alcohol, she may be required to return to the Detox program, see the Consulting

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Physician for assessment and further testing and/or return home, at the expense of the Referral Agency;

- Clients who demonstrate signs of intoxication or withdrawal will not be admitted to the 2<sup>nd</sup> Floor;

□ Clients in these circumstances will be requested to return to Detox until medically released.

**CLIENT NO SHOW**

- Admission Day will generally be on Mondays, in the event that a client does not arrive, the referral source will be contacted on Tuesday and advised that their client did not arrive for admission;
- Any no shows will be considered a cancellation: beds will be filled by those on the wait list;
- If a client calls to cancel, client will be asked to contact their referral source.

**WAITLIST MANAGEMENT**

- Clients appropriate for our program will be put on a **WAIT LIST** until a bed becomes available. The client is encouraged to continue preparing for treatment by engaging in pre-treatment services;
- **Once a bed is available, the client will be contacted by phone and an acceptance letter will be sent to the referring agency as well as the client, if possible;**
- One week prior to admission, we will conduct a telephone interview with the client and receive an update on Pretreatment services and/or client readiness;

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- Travel arrangements to and from the Centre, the responsibility of the referral worker or client, are be confirmed with our Intake office;

☐ The 2<sup>nd</sup> Floor may be able to facilitate transportation in certain circumstances. If transportation is an issue, contact the Residential Program Supervisor.

**RE-ADMISSION**

- Re-admission is defined as a request to return to the program after having chosen to self-discharge against the advise of the 2<sup>nd</sup> Floor or after having gone AWOL;
- Requests for re-admission will be processed on an individual basis. A file review and meeting with the Program Team will be required.

**REFERRAL AGENCY INFORMATION**

Name of Client: \_\_\_\_\_

DOB: \_\_\_\_\_

Estimated Due Date: \_\_\_\_\_

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Name of AGENCY: \_\_\_\_\_

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

Email Address: \_\_\_\_\_

Name of REFERRAL WORKER: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

To prepare the client for Residential Treatment Programming, please list the *medically supervised Detox Program* this client will be

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attending, include agency, name of worker, type of service provided:

**FUNDING INFORMATION**

Please provide the agency/service/group/etc. that will be providing treatment funding for this client:

Name: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone number: \_\_\_\_\_

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

**AFTERCARE PLANNING**

Will you be involved in this client's after care plan?

YES OR  NO

If yes, describe:

What aftercare & follow-up plans have been made between the client & worker?

YES OR  NO

If yes, describe:

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Will any support or counselling be offered to the family while the client is in treatment for recovery/healing initiatives?

YES OR  NO

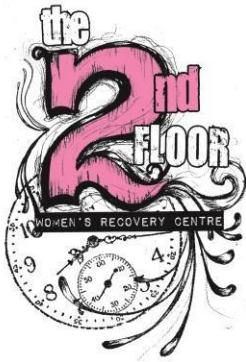
If yes, describe:

Additional Comments:

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The 2<sup>nd</sup> Floor Women's Recovery Centre Referral Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_
Birth Date: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_
Postal Code: \_\_\_\_\_
Telephone: \_\_\_\_\_
Health Card #: \_\_\_\_\_
Current Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_
In Case of Emergency Contact: \_\_\_\_\_
Relationship: \_\_\_\_\_
Emergency Contact Address: \_\_\_\_\_
Emergency Contact Telephone #: \_\_\_\_\_
Cultural Identification:

- Caucasian Black Asian Ukrainian French
Other

Aboriginal Ancestry: YES NO Status Non-Status Métis Inuit

Name of Band: \_\_\_\_\_ 10 Digit Band #: \_\_\_\_\_

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**PRESENT HEALTH CONDITIONS**

Estimated Due Date: \_\_\_\_\_

Pregnancy History:

*Please include live births, miscarriages & terminations*

Previous Pregnancy	Date	Concerns/Complications

Heart Disease  Yes  No    Diabetes  Yes  No    Epilepsy  Yes  No

~~Communicable Disease~~  Yes  No (i.e. HIV, STDs, HEP A/B/C, TB) Additional

Information:

Allergies  Yes  No

If yes, please list (food, medication, environmental)

Is a special diet indicated?  Yes  No

Have you had extended medical treatment?  Yes  No

Any previous diagnosis or referrals for diagnosis  Yes  No

If yes, please indicate diagnosis:

*(Please attach copy of diagnosis if important to treatment)*

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Additional Medical Information:

**MENTAL HEALTH**

Do you have a history of mental health conditions?  Yes  No

Condition Presented:

Please provide details: (date of diagnosis/conditions, current status)

Do you have a history of suicidal ideations/attempts?  Yes  No

If yes, provide details; include dates, method, factor(s) leading to ideation/attempt:

Can you provide details of intervention/counselling services provided to you at that time?

**A Progress/Assessment Report from the Psychiatrist, Physician, or Mental Health Counsellor/Therapist may be required for any client referred who has mental health condition/diagnosis.**

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**MEDICATIONS**

Current Medications	Purpose	Date Prescribed	Concerns/Complications

Past Medications (pertinent to pregnancy & treatment):

**CURRENT SUBSTANCE USE**

Substance	Frequency of use	Quantity of use	Duration of use	Situation/Triggers of use

**SUBSTANCE USE HISTORY**

Substance	Age of first use	Date of last use	Frequency of use	Quantity of use

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**PRIOR ALCOHOL & DRUG ABUSE TREATMENT**

**IN-PATIENT TREATMENT PROGRAMS:**

**Please list treatment programs Client has attended beginning with the most recent. If more space is required, please copy this page.**

Recommendations or Reports may be requested from the Facility to assist in the development of your Individual Recovery Plan.

Admission Date: \_\_\_\_\_

Duration: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

City: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Was treatment completed? \_\_\_\_\_

If no, state reason: \_\_\_\_\_

Duration of Abstinence following Treatment: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Duration: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

City: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Was treatment completed? \_\_\_\_\_

If no, state reason: \_\_\_\_\_

Duration of Abstinence following Treatment: \_\_\_\_\_

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**CLIENT'S CURRENT SITUATION**

**Living Arrangements:**  With Immediate Family  With Parents  
 Alone  With Extended Family  With Children  With Friends  
 Other: (Shelter, Detox, Transition House, Homeless, Recovery Home)

Are the people the client is living with using alcohol and/or drugs?

| Yes | No

Is the client expected to return to this home/residence?

| Yes | No

If no, identify new living arrangements

**MARITAL STATUS**

Single  Married Status  Me Common-Law  Divorced Status  Me Separated

Separation Date: \_\_\_\_\_ Other: \_\_\_\_\_

**LEGAL ISSUES**

Does the client have outstanding charges:  Yes  No

Indicate upcoming Court Date, if applicable: \_\_\_\_\_

Family Court Status  Me Criminal Court

***If yes, please provide a good copy of the Order.***

Is Treatment a Condition of the order?

Alone | No

Details:

Is the client currently on:  Bail  Parole  Probation

Other:

Details:

If the client is on probation, please provide name, agency, and contact information:

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Does the client have legal representation?  Alone |  No

If yes, please provide the name, agency/firm, and contact information:

Does the client have any past legal issues that may be pertinent or they would like the 2<sup>nd</sup> Floor Women's Recovery Centre to be aware of? If yes, please provide details:

**CLIENT EDUCATION**

Highest Level of Education Completed: \_\_\_\_\_

Trade/Technical Courses/Other Achievements:

English Language spoken by the client:  Yes  No Written:  Yes  No

Other Language spoken by the client:  Yes |  No

Please list languages: \_\_\_\_\_

Literacy Skills - Do you require assistance for reading and writing?

Alone |  No

Other Educational Related Information:

**CLIENT'S SOURCE OF INCOME**

E.I.:  AISH:  SFI:  Employment:

Other: \_\_\_\_\_

**EMPLOYMENT**

Employed |  Unemployed |  Retired |  Job Training  
 Student

Date of most recent employment: \_\_\_\_\_

Position: \_\_\_\_\_

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Where: \_\_\_\_\_

Length of Employment: \_\_\_\_\_

**CLIENT'S CHILDREN** (please use additional sheet of paper if necessary)

1. Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Child Resides With: \_\_\_\_\_

2. Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Child Resides With: \_\_\_\_\_

3. Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Child Resides With: \_\_\_\_\_

Is Child & Family Services involved with the client's immediate family?  Alone |  No

Are there any other service agencies involved with the client's immediate family?  Yes |  No

Are there conditions we need to be aware of?  Yes |  No

If yes, Please provide details:

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**ADDITIONAL RELATED INFORMATION**

Are there any Vision/Dental needs?  Alone |  No

If yes, please describe:

List skills, hobbies, interests, strengths, accomplishments the client is proud of:

Are there any issues or concerns that the client has regarding treatment at the 2<sup>nd</sup> Floor Women's Recovery Centre?  
We, the undersigned, agree that the information provided on this Referral Form is true and accurate to the best of our ability.

Signature of Worker: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Client: \_\_\_\_\_

Date: \_\_\_\_\_

**Please send completed Referral Package to:**  
**[abernicki@lcfasd.com](mailto:abernicki@lcfasd.com) OR**  
**Fax to confidential line @ 1.780.594.9907**  
**OR**  
**Mail to P.O. Box 479 Cold Lake, AB T9M 1P1**

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