



## **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 their pregnancy, the earlier the better. Due to the complications in detoxification, especially during pregnancy, we are unable to provide detox at the **2<sup>nd</sup> Floor**. Pregnant clients are required to attend a 5-7 day medically supervised detox program. Non-pregnant client who are unable to maintain sobriety prior to their intake date are also encouraged to attend a 5-7 day medically supervised detox program.

At the **2<sup>nd</sup> Floor**, each woman will have a private room with access to an Addictions Counsellor, Case Manager, Programmer, Health Services, and 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 Health Services to provide a medical baseline and, if necessary, a 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 Coordinator, Programmer and other services as needed. Strengths and needs will be

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identified, such as housing, finances, health, relapse prevention, parenting decisions, and a natural discharge date determined.

Each woman will be transitioned to their home community/community of choice, approximately one month prior to their delivery date, according to their After Care Plan; she will be provided information regarding types of services available in their 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 Self-Referral);
- ✓ Pre-Admission Form (signed by client and referring agency);
- ✓ Detox information/Admissions Medical form from supervising physician;
- ✓ Consent to Release of Information;

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, 1.780.594.9903 or 1.877.594.5454(t-f)

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**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 by:
  - \* Cash
  - \* Certified Cheque
  - \* Electronic Funds Transfer (EFT)
- If a Client self-discharges the funder will be invoiced \$80 (2days) to hold the bed in the event of their return.

**REFERRAL PROCESS/APPLICATION FOR TREATMENT**

Client may self-refer or be referred by any social agency.

**ACCEPTED PHYSICIAN PRESCRIBED TREATMENTS**

2<sup>nd</sup> Floor is able to provide alternative Physician prescribed treatments including:

- Opioid Agonist Therapy
  - \* Methadone Maintenance
  - \* Suboxone
- Medical Marijuana
  - \* This will be considered on a case by case basis

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**EXCLUSION OF SERVICES**

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

- **Psychoactive medications** but refuse to take them
- **Opioids** or **prescription narcotics** and refuse
  - \* Medication replacement must be established and in place prior to arrival at the 2<sup>nd</sup> Floor
- Accommodations for spouse/partner and/or children

**INTAKE PROCEDURES**

- Completion/submission of the **Referral Package**;
  - \* **Admission Medical** is a necessary document
- Telephone interview with the referral source and/or the 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**

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

- Complete a **medically supervised detox program**;
  - \* Pregnant clients MUST complete a 5-7 day medically supervised detox program;
  - \* Non-pregnant clients are encouraged to attend a 5-7 day medically supervised detox program as detox is not available at the 2<sup>nd</sup> Floor;
- Clients who are either taking prescription narcotics must either:
  - \* Detox from the prescribed medication altogether;
  - \* Wean off the prescription narcotic and have Physician replace with non-narcotic medication **prior to admission**;

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- Complete the **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 Health Services 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;

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**

- Monday-Thursday are admission days at the 2<sup>nd</sup> Floor;
  - \* There will be **no** admissions Friday-Sunday or on holidays;
  - \* 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 their mind regarding admission, please advise us as soon as possible;
  - \* If a client cancels their admission, the 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;

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**DRUG & ALCOHOL TESTING**

- Detox Program will be requested to forward client's Drug & Alcohol test results (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 will not be able to remain at the 2<sup>nd</sup> Floor.
- Clients who demonstrate signs of intoxication or withdrawal will not be admitted to the 2<sup>nd</sup> Floor;
  - \* Appropriate arrangements will be made based on individual circumstances for women who are unable to remain at the 2<sup>nd</sup> Floor.

**CLIENT NO SHOW**

- Admission Days are Monday-Thursday. In the event that a client does not arrive, the referral source will be contacted and advised the 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 Pre-treatment services and/or client readiness;
- Travel arrangements to and from the Centre, are the responsibility of the referral worker or client, and must be confirmed with 2<sup>nd</sup> Floor staff;

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- \* The 2<sup>nd</sup> Floor may be able to facilitate transportation in certain circumstances. If transportation is an issue, contact the 2<sup>nd</sup> Floor.

**RE-ADMISSION**

- Re-admission is defined as a request to return to the program after having chosen to self-discharge against the advice 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.

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**REFERRAL AGENCY INFORMATION**

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

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

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

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

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

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

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

To prepare the client for Residential Treatment Programming, please list the medically supervised Detox Program this client will be attending, include agency, name of worker, type of service provided:

\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT FUNDING INFORMATION**

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

Name: \_\_\_\_\_ File#: \_\_\_\_\_

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

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

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

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

**BENEFIT INFORMATION**

Name of Provider: \_\_\_\_\_

Client File#: \_\_\_\_\_

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**AFTERCARE PLANNING**

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

YES OR  NO

If yes, describe:

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

YES OR  NO

If yes, describe:

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:

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Additional Comments:

[Empty rectangular box for 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: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone#: \_\_\_\_\_

Health Care #: \_\_\_\_\_ Benefits#: \_\_\_\_\_

Current Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Emergency Contact Phone#: \_\_\_\_\_

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**

**Family Planning**

Is client currently on birth control?     Yes         No

What method? \_\_\_\_\_

Important info (i.e. date of next depo shot)

\_\_\_\_\_

Is client Pregnant?         Yes         No

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

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Have you had extended medical treatment?  Yes  No

Any previous diagnosis or referrals for diagnosis?  Yes  No

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

If yes, please indicate diagnosis:

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Additional Medical Information:

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**MENTAL HEALTH**

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

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

Condition Presented:

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

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

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

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Please provide details of intervention/counselling services provided at that time?

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**MEDICATIONS** (please use additional paper if necessary)

Please provide a typed copy of all current prescriptions

Current Medications	Purpose

Past Medications (pertinent to pregnancy & treatment):

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**CURRENT SUBSTANCE USE** (please use additional paper if necessary)

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

**SUBSTANCE USE HISTORY** (please use additional paper if necessary)

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:**  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       Common-Law    Divorced       Separated

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

**LEGAL MATTERS**

Does the client have outstanding charges:  Yes  No

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

- Family Court       Criminal Court

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

Is Treatment a Condition of the order?  Yes       No

Details:

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Is the client currently on:  Bail       Parole    Probation

Other:

Details:

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

\_\_\_\_\_  
\_\_\_\_\_

Does the client have legal representation?  Yes  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?

Yes  No

Other Educational Related Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**CLIENT'S SOURCE OF INCOME**

E.I.:  AISH:  SFI:  Employment:

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

**EMPLOYMENT**

Employed       Unemployed       Retired       Job Training  
 Student

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

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

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?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

If yes, Please provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION**

Are there any Vision/Dental needs?  Yes  No

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

List skills, hobbies, interests, strengths, and accomplishments the client enjoys or 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:**

[admin@lcfasd.com](mailto:admin@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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