Northern Ontario Addiction Treatment
Centre of Excellence

APPLICATION FORM		
INSTRUCTIONS: Complete and submit online. You will be contacted by the Care Coordinator to schedule your intake assessment.		
MAILING ADDRESS: 352 Lakeshore Dr. North Bay, ON P1A 2C2	**WEBSITE:** Detailed information on our programs and the assessment process can be found at www.northernaddictiontreatmentcentre.ca	**Email** Care Coordinator: info@northernaddictiontreatmentcentre.ca
FOR OFFICE USE ONLY Referral date:		
Status: ☐ Ministry of Health ☐ Provincial Corrections ☐ Federal Corrections ☐ Fee-for-Service		

START APPLICATION HERE

PERSONAL INFORMATION		
First Name:	Last Name:	
Full name at birth (if different than above):		
If you use an alternative name, please include it:		
Date of Birth:	Gender:	Pronouns:
Do you have an Ontario Health Card? ☐ Yes ☐ No	Health Card Number:	
Status Card #:	Band #:	
Non-Insured Health Benefit #:		
Home Address:	City:	Province:
Postal Code:	Do you have a fixed address? ☐ Yes ☐ No	
Phone Number:	Ok to leave a message? ☐ Yes ☐ No	
Emergency Contact:	Relationship:	
Emergency Contact Phone #:	Ok to leave a message? ☐ Yes ☐ No	
Language you prefer to receive service in?		
Ethnicity (e.g. Canadian, First Nations, Irish, etc.):	Birthplace:	

REFERRAL INFORMATION		
Please specify the referring agency and contact name:		
Please check the boxes that explain who referred you to NOATCE:		
☐ Self	☐ Day/Evening Addiction Services	☐ 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 Heath Centre	☐ Police
☐ Residential Addiction Treatment	☐ Physician/Private Practice	☐ Other Legal
☐ Supportive Housing	☐ Public Health Unit Nurse	☐ Connex Website
☐ Outpatient Addiction Services	☐ Community Mental Health	☐ Other

EMPLOYMENT STATUS		
☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed (looking for work)	☐ Student/Re-training ☐ Disability	☐ Not in Labor Force (e.g. homemaker) ☐ Retired
EDUCATION (HIGHEST LEVEL ACHIEVED)		
☐ No formal chooling ☐ Some Primary School ☐ Completed Primary School	☐ Some Secondary or High School ☐ Completed Secondary or High School ☐ Some College/CEGEP	☐ Completed College/CEGEP ☐ Some University ☐ Completed University Degree/Masters/ PhD
INCOME SOURCE		
☐ Disability Insurance ☐ Employment ☐ Employment Insurance (E.I.) ☐ Family Support	☐ None ☐ Ontario Disability (ODSP) ☐ Ontario Works (OW)	☐ Other Insurance (excluding E.I.) ☐ Retirement Income ☐ Other

PREVIOUS TREATMENT INFORMATION

Have you had previous substance use treatment? ☐ No ☐ Yes (if yes, complete chart below)

Treatment Facility/Location	Type of Treatment	Date Attended (mm/yyyy)	Program Length	Completed?
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

Have you had previous treatment at NOATCE? ☐ No ☐ Yes If yes, when:

What led to your relapse?

IDENTIFIED FAMILY

Please identify your current relationship status:

☐ Married ☐ Partnered/Common Law ☐ Single (never married) ☐ Divorced/Separated ☐ Widow/Widower

Please identify your immediate family members in the chart below:

Family Member Name/ Support person	Relationship	Age	Do you have contact with them?	Are they supportive of Treatment?	Do they have problematic substance use?

IDENTIFIED FAMILY continued

If you have children, please complete the chart below:

Name of Child	Age	Who do they live with?	Who has custody?

Are you currently involved with any of the following services? Check all that apply:
☐ Family & Children's Services ☐ First Nations Family Services ☐ Other (please specify):

LEGAL STATUS

Legal Status:
☐ None ☐ Awaiting Trial or Sentencing ☐ On Probation ☐ On Parole ☐ Incarcerated
☐ Bail, who is surety: Surety contact info:
☐ Other, please specify:

FPS#: OTIS#:

Are you applying to NOATCE for probation/parole? ☐ No ☐ Yes

If yes, please indicate type: ☐ Provincial ☐ Federal-Day Parole ☐ Federal-Full Parole

What is your Parole Eligibility date? (dd/mm/yyyy):

If incarcerated, what institution are you currently at?

Probation/Parole Officer: Phone:

Lawyer: Phone:

Treatment Mandated or 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, please specify:

Do you currently have Young Offender status? ☐No ☐ Yes

Do you have any charges, fines, or warrants outstanding or pending? ☐ No ☐ Yes (if yes, please explain below)

Please list any upcoming court dates:

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

Are you currently participating in a Drug Treatment Court program? ☐ No ☐ Yes
If yes, please provide your Drug Treatment Court Worker's name:
Phone Number:
Permission to contact? ☐ No ☐ Yes
Currently attending Back on Track? ☐ No ☐ Yes If yes, start

PHYSICAL HEALTH STATUS
Family Doctor (if applicable): Phone Number:
Please check any health issues that apply to you: ☐ Visual Impairment ☐ Mobility concerns ☐ Communicable diseases (e.g. Hepatitis, HIV) ☐ Hearing impairment ☐ Pregnant, if yes: Due Date: ☐ Acquired Brain Injury
Please describe your physical health concerns:
Please list any allergies:
Please list any dietary requirements:
Please indicate the number of overnight hospitalizations in the last 12 months for physical problems:
Please indicate the number of Emergency Department visits in the last 12 months for any issue:
Reason for most recent hospitalization:
Have you been diagnosed with a developmental or learning disability? ☐ No ☐ Yes (if yes, please explain below)
MENTAL HEALTH STATUS
Have you received a mental health diagnosis by a mental health professional? Within the last 12 months? ☐ No ☐ Yes Within your lifetime? ☐ No ☐ Yes
If yes, please explain:
Have you been hospitalized for a mental health concern within the last 12 months? ☐ No ☐ Yes
Have you been hospitalized for a mental health concern within your lifetime? ☐ No ☐ Yes
Have you received treatment for mental health, emotional, behavioral or psychological concern from a professional? Currently ☐ No ☐ Yes Within the last 12 months? ☐ No ☐ Yes Within your lifetime? ☐ No ☐ Yes
Name of service provider: Phone Number:
Do you engage in any self-harm behaviors (e.g. cutting)? ☐ No ☐ Yes (if yes, what?):
Have you ever attempted suicide? ☐ No ☐ Yes (if yes, when?):
Have you ever overdosed? ☐ No ☐ Yes (if yes, when?):
Have you ever injected drugs for non-medical use? ☐ Never injected ☐ Injected within the past year ☐ Injected over a year ago
Do you currently struggle with an eating disorder? ☐ No ☐ Yes
In the past, have you struggled with an eating disorder? ☐ No ☐ Yes

MEDICATIONS (ARE YOU CURRENTLY PRESCRIBED CBD, PSILOCYBIN OR KETAMINE?)	
Please list all your current medication(s):	Please indicate your current dosage(s):
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Have you been prescribed medication for mental health concerns?

Currently? ☐No ☐Yes Within the last 12 months? ☐No ☐Yes Within your lifetime? ☐No ☐Yes

OPIOID REPLACEMENT

Are you currently participating in opioid replacement therapy? ☐ No ☐ Yes (if yes, please indicate below)

☐ Methadone ☐Suboxone ☐ Sublocade

If yes, who is your prescriber?

What is your current dosage?

SUBSTANCE USE HISTORY

What are your current substances of choice? Please list in order of severity. During active substance use, how frequently would you use each substance?

Substance of Choice		Frequency in Active Substance Use		Method of Use	
1.	Age of first Use:	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
2.	Age of first Use:	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
3.	Age of first Use:	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
4.	Age of first Use:	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
5.	Age of first Use:	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed

Additional information:

SUBSTANCE USE HISTORY continued			
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 and 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
☐ Heroin/Opium		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Methamphetamines (e.g. crystal meth)		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Other psychoactive 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:		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Other:		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
☐ Other:		☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed

GAMBLING	
Have you ever had gambling identified as a problem? ☐ Yes ☐ No	
Would you be interested in treatment for gambling? ☐ Yes ☐ No	
Please indicate below any gambling activities engaged in the past 12 months:	
☐ Bingo ☐ Slot machines ☐ Gambling machines (other than slots) ☐ Casino card or table games ☐ Non-casino card to table games ☐ Horse races ☐ Sports betting	☐ Lottery tickets ☐ Instant win or scratch tickets ☐ Internet gambling ☐ Gambling with stock market or real estate ☐ Betting on games of skill ☐ Betting on outcome or event

Are there any other addictions you struggle with?

☐ Sex ☐ Porn ☐ Internet ☐ Eating Disorder ☐ Food Addiction ☐ Shopping

☐ Relationships ☐ Other, please describe:

Why do you want to attend residential treatment?

Miscellaneous
Have you faced any of the following barriers? Check all that apply. ☐ Education/literacy barriers ☐ Employment barriers/lack of job skills ☐ Food insecurity ☐ Trauma (in past year) ☐Trauma (in lifetime) ☐ Poverty ☐ Housing insecurity/homelessness ☐ Incarceration ☐ Mental health issues ☐ Violence/abuse ☐ Language barriers ☐ Others, please specify: Do you have any gang affiliation? Do you have any family or friends with gang affiliation? Please elaborate. Is there any other information you believe is important for the Northern Ontario Addiction Treatment Centre of Excellence to know?
DATE THIS FORM WAS COMPLETED:

THANK YOU FOR COMPLETING THE APPLICATION FORM

FOR OFFICE USE ONLY
Has the assessment been completed? ☐ Yes ☐ No
Date the assessment was completed:
If no assessment was completed, please indicate why:
Admissions Staff Name:
Admissions Staff Signature:
Reviewed and updated on admission ☐ Yes ☐ No
Date:
Staff Signature **Client Signature**

Submit Application