

**TOP OF THE WORLD RANCH TREATMENT CENTRE**

*Admissions Information Record*

Client Name		Date	
DOB		Health Card#	
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Email Address
Primary Number		Alternate Number	
Safe to Leave Messages		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Street Address		City	
Province		Postal Code	
Marital Status		Children/Dependents	
Emergency Contact		Children residing w/client	Yes <input type="checkbox"/>
Relationship		Phone Number	Email
Family Doctor		Office Number	
Height		Eye Color	
Weight		Hair Color	
Identifying Features			

**Addiction History**

Substance/Behaviour	Ever used? Y or N	Amount / How Much	Frequency / How Often	First Use	Last Use	Duration Years/Months
Alcohol						
Marijuana/Hash						
Opioids <i>heroin, morphine, dilaudid, oxy, fentanyl</i>						
Amphetamines <i>crystal meth, dexedrine</i>						
Cocaine/Crack						
Hallucinogens <i>mushrooms, LSD, salvia</i>						
Club drugs <i>Ecstasy, Ketamine, GHB</i>						

**Addiction History Cont'd**

Substance/Behaviour	Ever used? Y or N	Amount / How Much	Frequency / How Often	First Use	Last Use	Duration Years/Months
Benzodiazepines <i>Valium, Ativan, Xanax</i>						
Prescription Medications <i>Pain Relievers, Other</i>						
Over the Counter Medications <i>Cough Suppressant, Muscle Relaxants, Antihistamines</i>						
Tobacco						

**Other Addictive Behaviours**  
*Shopping, Gambling, Sex/Pornography, Work, Love /Relationships, Excessive Exercise, Emotional Eating*

Have you ever had auditory hallucinations or drug induced psychosis? Yes  No

If yes, please provide detail

Is the client on methadone? Yes  No  If yes, how long?

Current dosage: any impact on alertness? Yes  No

Prescribing Doctor Phone Fax

**ETOH for Alcohol**

What type of alcohol do you consume? *(vodka, wine, beer etc)*

What are your drinking habits/patterns?

In the past when you have tried to stop drinking, what happened?

What was the withdrawal like?

Did you experience any of the following symptoms?

Dehydration       Sweats       Pneumonia       Hallucinations       Other (explain)  
 Anxiety       Fear       DT's       Seizures

Please provide detail regarding history of withdrawal seizures

**PLEASE COMPLETE - IF PERSON IS TAKING ANY BENZODIAZEPINES**

Benzodiazepines *(Clonazepam, Ativan, Diazepam, Lorazepam etc.)*

Are these prescribed medications?

Have you ever misused these medications? Or taken more than prescribed?

How long have you been taking these medications for?

If recommended, would you be willing to taper off of these medications?

Medications					
Medication Name	Dose (mg)	Qty	Time of Day Taken	PRN <i>(as needed)</i>	Reason Taken
Pharmacy & Location			Phone Number		
<i>Please note: Clients are asked to arrive at the Ranch with current, valid <b>prescriptions</b> with refills sufficient for at least 30 days OR have prescriptions transferred from home Pharmacy</i>					
Please list any over the counter medications or herbal remedies:					
Health Assessment					
Food Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>
List					
Describe Reaction					
Diabetic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Insulin - Type 2	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes well managed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gastrointestinal Conditions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Migraines	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bulimia	Yes <input type="checkbox"/> No <input type="checkbox"/> current / past
Hypo / Hyper - glycemic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Failure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anorexia	Yes <input type="checkbox"/> No <input type="checkbox"/> current / past
Vegetarian	Yes <input type="checkbox"/> No <input type="checkbox"/>	Serosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Learning Disabilities	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lactose Intolerant	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hep B / Hep C	Yes <input type="checkbox"/> No <input type="checkbox"/>	Injuries / Accidents	Yes <input type="checkbox"/> No <input type="checkbox"/>
Celiac Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV / Aids	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chronic Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Crohns Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Failure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy / Seizure Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Colitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Brain Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Suicidal Thoughts	Yes <input type="checkbox"/> No <input type="checkbox"/> current / past
Sodium Controlled Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Suicide Attempts	Yes <input type="checkbox"/> No <input type="checkbox"/> current / past
Pancreatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Self-Harm	Yes <input type="checkbox"/> No <input type="checkbox"/> current / past
<b>Please Provide Detail</b>					
Religious or Other Dietary Restrictions, Please List					
Favorite Food					

TB Screening					
Chronic Cough <i>(more than 2 weeks)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	First Nations AND On Reserve	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Productive Cough <i>(mucus/phlegm)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Recent/Past Exposure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bloody Sputum <i>(haemoptysis)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Previous active TB and Tx	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weight loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Positive Mantoux test / CXR	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Night Sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hx Birth / Travel in a country with high incidence of TB	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fever <i>(often low grade)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hx correctional facility or long term care facility	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hx Intravenous drug use / substance abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Immunizations					
<i>To the best of your knowledge:</i>					
Fully Immunized	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Immunized as a Child	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Immunized through Work	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Immunized for Travel	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Flu Vaccine this year	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If NO, interested in Flu Vaccine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Interested in Other Immunizations	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Have you ever had an Adverse Reaction to Immunizations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Please specify.					
Intensive Residential Treatment Readiness					
Mental Health Diagnoses or Concurrent Disorders?  <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> OCD  <input type="checkbox"/> PTSD <input type="checkbox"/> Bipolar <input type="checkbox"/> ADHD  <input type="checkbox"/> BPD - Borderline Personality <input type="checkbox"/> Other	Physical Abuse?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Sexual Abuse?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Domestic Abuse?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Safe Housing/Living Situation?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Please Provide Brief Detail	Other Trauma or Loss?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Please Provide Brief Detail				
Prior / Current Counseling?		Yes <input type="checkbox"/> No <input type="checkbox"/>	See(n) a Psychologist / Psychiatrist?		Yes <input type="checkbox"/> No <input type="checkbox"/>
IF YES, Clinicians Name & Contact					
Please Provide Brief Detail - <i>reason for counseling, assessments done</i>					
Previous Treatment		Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Outpatient or <input type="checkbox"/> Residential	<input type="checkbox"/> Multiple Treatment Programs	
Treatment Program (s)					
Complete	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date (s)		





# Agreement of Payment for Residential Treatment

I, \_\_\_\_\_ agree to pay Top of the World Ranch Ltd. for the full cost of residential treatment for \_\_\_\_\_.

30 days	___	\$15,950.00	Detox	-	\$ 550.00 per night
45 days	___	\$21,950.00	Detox ONLY	-	\$ 700.00 per night
60 days	___	\$27,950.00	Other	-	\$
90 days	___	\$39,950.00			

*All funds are in Canadian dollars and not inclusive of 5% GST*

**A \$4000 non-refundable deposit is required to secure your space and treatment date. The remainder of payment is due upon arrival.**

Our refund policy is as follows;

- I. When a medical discharge takes place as described in a & b below, the payee will receive a prorated refund for the remainder of their planned stay with us, less \$2,500 of the deposit.
  - a. When a medical discharge is deemed necessary, and is initiated by Top of the World Ranch Treatment Centre staff, for previously disclosed ailments.
  - b. For a medical discharge initiated by a medical physician concerning an ailment(s) not previously known to the client or treatment centre staff.
- II. If a client chooses to leave treatment prior to the completion of their program OR a client is asked to leave treatment for not adhering to their treatment agreement, such as rule breaking and lack of participation, a prorated refund will be issued for the remainder of their stay, minus the non-refundable deposit of \$4,000 and a \$550 empty room charge. Both of which are applied to the end of the stay therefore no refund is provided for the last nine days of treatment.

*\*Any monies owing to the ranch will subtracted from any refunds issued for any reason. The refund is calculated beginning the day after discharge.*

## PAYMENT

I further agree to reimburse Top of the World Ranch Ltd. for additional costs incurred during treatment (i.e. doctors' visits, prescriptions, massage therapy, etc.). Top of the World Ranch does not monitor client use of services. It is the responsibility of the Client and the Payee to establish financial limits. Payment for additional fees is due prior to client discharge. Credit card info listed below will be used for this purpose. Top of the World Ranch will notify the appropriate individual who is paying for the clients stay in the case of an early discharge.

Payer's Signature: \_\_\_\_\_

Payer's Name (please print) \_\_\_\_\_

## Payment Information

Form of payment \_\_\_ VISA \_\_\_ MC \_\_\_ Amex \_\_\_ Cheque \_\_\_ Money Order

Credit Card # \_\_\_\_\_ Expiry Date (mm / yyyy) \_\_\_\_\_

Name on Card (please print) \_\_\_\_\_

Payers Signature; \_\_\_\_\_ Date \_\_\_\_\_

**THIS DOCUMENT MUST BE COMPLETED AND FAXED 24 HOURS PRIOR TO ADMISSION. PLEASE FAX COMPLETED FORM TO 250.426.6377.**