TOP OF THE WORLD RANCH TREATMENT CENTRE

Admissions Information Record

Client Name		Date	
DOB		Health Card#	
Gender	Male ☐ Female ☐	Email Address	
Primary Number		Alternate Number	
Safe to Leave Messages	Yes ☐ No ☐	Best time to reach you	
Street Address		City	
Province		Postal Code	
Marital Status		Children/Dependents	
Emergency Contact		Children residing w/client	Yes ☐ No ☐
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 *heroin, morphine, dilaudid, oxy, fentanyl*						
Amphetamines *crystal meth, dexedrine*						
Cocaine/Crack						
Hallucinogens *mushrooms, LSD, salvia*						
Club drugs *Ecstasy, Ketamine, GHB*						

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 *Valium, Ativan, Xanax*						
Prescription Medications *Pain Relievers, Other*						
Over the Counter Medications *Cough Suppressant, Muscle Relaxants, Antihistamines*						
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 recommmended, would you be willing to taper off of these medications?

Medications

Medication Name	Dose (mg)	Qty	Time of Day Taken	PRN *(as needed)*	Reason Taken

Pharmacy & Location	Phone Number

*Please note: Clients are asked to arrive at the Ranch with current, valid **prescriptions** with refills sufficient for at least 30 days OR have prescriptions transferred from home Pharmacy*

Please list any over the counter medications or herbal remedies:

Health Assessment

Food Allergies	Yes ☐ No ☐	Drug Allergies	Yes ☐ No ☐	Other Allergies	Yes ☐ No ☐
List					
Describe Reaction					

Diabetic	Yes ☐ No ☐	Insulin - Type 2	Yes ☐ No ☐	Diabetes well managed?	Yes ☐ No ☐

Gastrointestinal Conditions	Yes ☐ No ☐	Migraines	Yes ☐ No ☐	Bulimia	Yes ☐ No ☐	current / past
Hypo / Hyper - glycemic	Yes ☐ No ☐	Liver Failure	Yes ☐ No ☐	Anorexia	Yes ☐ No ☐	current / past
Vegetarian	Yes ☐ No ☐	Serosis	Yes ☐ No ☐	Learning Disabilities	Yes ☐ No ☐	
Lactose Intolerant	Yes ☐ No ☐	Hep B / Hep C	Yes ☐ No ☐	Injuries / Accidents	Yes ☐ No ☐	
Celiac Disease	Yes ☐ No ☐	HIV / Aids	Yes ☐ No ☐	Chronic Pain	Yes ☐ No ☐	
Crohns Disease	Yes ☐ No ☐	Heart Failure	Yes ☐ No ☐	Epilepsy / Seizure Disorder	Yes ☐ No ☐	
Colitis	Yes ☐ No ☐	Brain Injury	Yes ☐ No ☐	Suicidal Thoughts	Yes ☐ No ☐	current / past
Sodium Controlled Diet	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐	Suicide Attempts	Yes ☐ No ☐	current / past
Pancreatitis	Yes ☐ No ☐	Heart Problems	Yes ☐ No ☐	Self-Harm	Yes ☐ No ☐	current / past

Please Provide Detail

Religious or Other Dietary Restrictions, Please List

Favorite Food

TB Screening

Chronic Cough *(more than 2 weeks)*	Yes ☐	No ☐	First Nations AND On Reserve	Yes ☐	No ☐
Productive Cough *(mucus/phlegm)*	Yes ☐	No ☐	Recent/Past Exposure	Yes ☐	No ☐
Bloody Sputum *(haemoptysis)*	Yes ☐	No ☐	Previous active TB and Tx	Yes ☐	No ☐
Weight loss	Yes ☐	No ☐	Positive Mantoux test / CXR	Yes ☐	No ☐
Night Sweats	Yes ☐	No ☐	Hx Birth / Travel in a country with high incidence of TB	Yes ☐	No ☐
Fever *(often low grade)*	Yes ☐	No ☐	Hx correctional facility or long term care facility	Yes ☐	No ☐
Fatigue	Yes ☐	No ☐	Hx Intravenous drug use / substance abuse	Yes ☐	No ☐

Immunizations

To the best of your knowledge:

Fully Immunized	Yes ☐	No ☐		
Immunized as a Child	Yes ☐	No ☐		
Immunized through Work	Yes ☐	No ☐		
Immunized for Travel	Yes ☐	No ☐		
Flu Vaccine this year	Yes ☐	No ☐	If NO, interested in Flu Vaccine?	Yes ☐ No ☐
Interested in Other Immunizations	Yes ☐	No ☐		

Have you ever had an Adverse Reaction to Immunizations? Yes ☐ No ☐

Please specify.

Intensive Residential Treatment Readiness

Mental Health Diagnoses or Concurrent Disorders?

☐ Depression ☐ Anxiety ☐ OCD

☐ PTSD ☐ Bipolar ☐ ADHD

☐ BPD - Borderline Personality ☐ Other

Please Provide Brief Detail

Physical Abuse?	Yes ☐	No ☐
Sexual Abuse?	Yes ☐	No ☐
Domestic Abuse?	Yes ☐	No ☐
Safe Housing/Living Situation?	Yes ☐	No ☐
Other Trauma or Loss?	Yes ☐	No ☐

Please Provide Brief Detail

Prior / Current Counseling? Yes ☐ No ☐ See(n) a Psychologist / Psychiatrist? Yes ☐ No ☐

IF YES, Clinicians Name & Contact

Please Provide Brief Detail - *reason for counseling, assessments done*

Previous Treatment Yes ☐ No ☐ ☐ Outpatient or ☐ Residential ☐ Multiple Treatment Programs

Treatment Program (s)

Complete Yes ☐ No ☐ Date (s)

Legal History			
History of Violence, Assault	Yes ☐ No ☐	Pending Court Appearances	Yes ☐ No ☐
Possession, Trafficking of Narcotics	Yes ☐ No ☐	Outstanding warrants	Yes ☐ No ☐
Current Legal Involvement	Yes ☐ No ☐	Probation or Parole	Yes ☐ No ☐

Please Provide Detail

Survey Questions
What are your personal goals regarding treatment?
What do you feel may be your challenges during your treatment stay?
Has there been any recent involvement with self-support Groups, i.e. NA, AA, ACOA etc.?

Additional Comments

Referral Agent	☐ Self Referral / Family Member ☐ Counselor / Doctor ☐ Employer ☐ Alumni ☐ Other		
Funding Provider		Method of Payment	
Relationship	Phone Number	Email	
Length of Stay	☐ Undecided ☐ 30 Days ☐ 45 Days ☐ 60 Days ☐ 90 Days ☐ As Needed ☐ **Detox Required**		

For Office Use
Name of Staff Completing AIR
Concerns Regarding Final Approval
Approved By
☐I have informed client of approval
☐I have informed client of non-refundable $4000 deposit
☐I have informed the client of the drug screening test upon arrival at Top of the World and the consequences if positive
☐I have informed the client about our family program
☐I have informed the client about mandatory A/A, N/A self-support groups 4 times/week
☐I have informed the client about mass chores on Sunday and evenings and weekly chores assignments
☐I have informed the client about the required minimum 5 days detoxification
☐ I have informed the client about the semi-private accommodations

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	____	$16,950.00	Detox Program	____	$ 650.00 per night
45 days	____	$23,750.00	Detox ONLY	____	$ 775.00 per night
60 days	____	$29,950.00	Other	____	$_____
90 days	____	$41,950.00			

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 $650 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. F for additional costs incurred during treatment including doctors' visits, prescriptions, massage therapy, acupuncture, on site store purchases, cigarettes, in town purchases (this may include but is not limited to forgotten toiletries and clothing items). 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) _____

Payer's Signature _____Date _____

Payer's Phone Number _____

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