

Top of the World Ranch Treatment Centre Admissions Information Record		
DEMOGRAPHICS		
Client Name:	Age:	Date:
Date of Birth:	Health Card #:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/>	Email Address:	
Phone #:	Alt Phone #:	
May we leave a message? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is there a best time of day to reach you? Yes <input type="checkbox"/> No <input type="checkbox"/> If "YES," when?	
Street Address:		City:
Mailing Address:		
Province:	Postal Code:	Country:
RELATIONSHIP/DEPENDENTS		
Marital Status:	Dependents: Yes <input type="checkbox"/> No <input type="checkbox"/>	Do children reside with you? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Names & Ages:	
EMERGENCY CONTACT INFORMATION		
Emergency Contact:		Phone #:
Relationship to Client:		
Mailing Address:		City:
Province:	Postal Code:	Country:
Email Address:		
PERSONAL INFORMATION		
Height:	Weight:	Eye Colour:
Hair Colour:	Tattoos:	Religious/Spiritual Affiliation:
Identifying Features:		

Current Employment (include company and position):

If treatment will impact your employment, please explain:

REFERRAL SOURCE

Please check one of the following referral source boxes:

Self-Referral Family Member Counsellor Doctor Employer Alumni Other

Name of Referring Individual:

Phone #:

Contact information for referral source:

Name of Person Completing the Application (e.g., client, family member, Ranch staff):

LEGAL HISTORY

History of Violence:

Yes No

Pending Court Date:

Yes No

If "YES," when?

Outstanding Warrants:

Yes No

Probation: Yes No

Parole: Yes No

Other legal issues: Yes No

If "YES" to any of the above, please explain in detail (please include any potential court involvement that might impact your stay in treatment):

SUBSTANCE USE HISTORY

Alcohol

Ever Used	Date First Use	Frequency	Tried to stop?	Duration of No Use	Date Last Use	Usual Daily/Weekly Quantity
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>			

What type of alcohol do you consume? (e.g., Vodka, Wine, Beer etc.)

Have you ever consumed non-beverage alcohol, such as hand sanitizer, antifreeze, eau-du-cologne?

Yes No

If "YES," please describe what, how often, first and last use.

What are your drinking habits or patterns (e.g., daily, weekends)?

In the past when you tried to stop drinking, describe what happened, what your withdrawal was like:

Did you experience any of the following withdrawal symptoms? (Check all that apply)

Dehydration Sweats Anxiety Fear Seizures Hallucinations Delirium Tremens (e.g., confusion, shaking, irregular heartbeat, sweating, visual or auditory hallucinations) Pneumonia

If "YES" to any of the above, please describe:

Marijuana/Hash/ Shatter, etc. (Include medical marijuana) Please specify:

Ever Used	Date First Use	Frequency	Tried to stop?	Duration of No Use	Date Last Use	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

Opioids (Heroin, Morphine, Dilaudid, Oxy's, Fentanyl etc.). Please specify:

Ever Used	Date First Use	Frequency	Tried to Stop?	Duration of No Use	Date Last Use	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

Are you presently on any opiate replacement therapy (ORT)?

Yes No

If "Yes," which therapy? Methadone Suboxone How long? _____

Current Dosage: _____ Impact on Alertness: _____

Name of Clinic/Prescribing Physician: _____

Address: _____

Phone: _____ Fax: _____

If you are not already on opiate replacement therapy (ORT), do you wish to use an opiate replacement therapy?

Yes No

I have been informed of and agree to schedule an aftercare appointment for ORT while in treatment here.

Yes No

If I have been using opiates prior to coming to treatment (usually within past month), I am aware that I will be admitted to detox for a period of assessment?

Yes No

If you are on an opioid other than ORT our policy and practice is to taper clients off of opioids. Are you willing to work with the Ranch doctor to taper off of any opioids? Yes No

Amphetamines (e.g., Crystal Meth, Dexedrine, Adderall). Please specify:

Ever Used	First Use	Frequency	Tried to Stop?	Duration of No Use?	Date Last Use	How Much?	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

Were any amphetamines prescribed to you by a physician? Yes No

If "YES," list the prescribing physician:

Physician contact information (including phone number):

Have you ever misused or abused (not taken) these medications (amphetamines) as prescribed? Yes No

If "YES," please explain:

Cocaine/Crack. Please specify:

Ever Used	Date First Use	Frequency	Tried to stop?	Duration of No Use?	Date Last Use?	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

Hallucinogens (e.g., Mushrooms, LSD, Salvia,). Please specify:							
Ever Used Yes <input type="checkbox"/> No <input type="checkbox"/>	Date First Use	Frequency	Tried to Stop? Yes <input type="checkbox"/> No <input type="checkbox"/>	Duration of No Use?	Date Last Use?	Quantity	Route of Administration (How used?)
Club Drugs (e.g., Ecstasy, Ketamine, GHB). Please specify:							
Ever Used Yes <input type="checkbox"/> No <input type="checkbox"/>	Date First Use	Frequency	Tried to Stop? Yes <input type="checkbox"/> No <input type="checkbox"/>	Duration of No Use?	Date Last Use?	Quantity	Route of Administration (How used?)
Benzodiazepines (e.g., Valium, Ativan, Xanax, Clonazepam). Please specify:							
Ever Used Yes <input type="checkbox"/> No <input type="checkbox"/>	Date First Use	Frequency	Tried to stop? Yes <input type="checkbox"/> No <input type="checkbox"/>	Duration of No Use?	Date Last Use?	Quantity	Route of Administration (How used?)
<p><i>Were these medications (benzodiazepines) prescribed to you? Yes <input type="checkbox"/> No <input type="checkbox"/></i></p> <p>If "YES," list the prescribing physician:</p> <p>CONTACT INFORMATION OF PRESCRIBING PHYSICIAN if different than Family/General Practice Physician listed below (including phone number):</p>							
<p><i>Have you ever misused or abused these medications (benzodiazepines) as prescribed? In other words, have you taken them in a way that was not prescribed?</i></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "YES," please explain:</p>							
<p><i>How long have you been taking these medications (benzodiazepines)?</i></p>							

If you are on benzodiazepines our policy and practice is to taper clients off of benzodiazepines. Are you willing to work with the Ranch doctor to taper off of any benzodiazepines? Yes No

Barbiturates (e.g., Seconal, Nembutal, Amytal). Please specify:

Ever Used	Date First Use	Frequency	Tried to Stop?	Duration of No Use?	Date Last Use?	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

Were these medications (barbiturates) prescribed to you? Yes No

If "YES," list the prescribing physician:

Contact information of prescribing physician if different than Family/General Practice Physician listed below (including phone number):

Have you ever misused or abused these medications (barbiturates) as *prescribed*? In other words, have you taken them in a way that was not prescribed?

Yes No

If "YES," please explain:

How long have you been taking these medications (barbiturates)?

If you are on barbiturates our policy and practice is to taper clients off of barbiturates. Are you willing to work with the Ranch doctor to taper off of any barbiturates? Yes No

Performance Enhancing Drugs (e.g., anabolic steroids such as testosterone, synthetic steroids, Androstenedione (andro)). Please specify:

Ever Used	Date First Use	Frequency	Tried to Stop?	Duration of No Use?	Date Last Use?	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

Tobacco (e.g., cigarettes, chewing tobacco). Please specify:							
Ever Used Yes <input type="checkbox"/> No <input type="checkbox"/>	Date First Use	Frequency	Tried to stop? Yes <input type="checkbox"/> No <input type="checkbox"/>	Duration of No Use?	Date Last Use?	How Many per day?	Would you like to stop? Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Addictive Behaviors:					If "YES" to Other Addictive Behavior(s), please describe how these behaviors are negatively affecting your life:		
Shopping	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gambling	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sex/Porn			
Relationships	Yes <input type="checkbox"/> No <input type="checkbox"/>	Exercise	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emotional Eating	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gaming	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you or others see any of these behaviors as NEGATIVELY IMPACTING YOUR LIFE, such as relationships or work? Yes <input type="checkbox"/> No <input type="checkbox"/>							

HEALTH ASSESSMENT	
Are you Diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/>	Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>
Insulin Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/>	Medication? Yes <input type="checkbox"/> No <input type="checkbox"/>
If "YES," is your Diabetes well and consistently managed? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Gastrointestinal Issues: Yes <input type="checkbox"/> No <input type="checkbox"/>	Celiac Disease: Yes <input type="checkbox"/> No <input type="checkbox"/>
Hypo/Hyper Glycemic: (please circle) Yes <input type="checkbox"/> No <input type="checkbox"/>	Crohn's Disease: Yes <input type="checkbox"/> No <input type="checkbox"/>
Potentially Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/>	Colitis Yes: <input type="checkbox"/> No <input type="checkbox"/>
Pancreatitis: Yes <input type="checkbox"/> No <input type="checkbox"/>	Irritable Bowel Syndrome (IBS): Yes <input type="checkbox"/> No <input type="checkbox"/>
Migraines: Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Failure or low function: Yes <input type="checkbox"/> No <input type="checkbox"/>
Cirrhosis Yes: <input type="checkbox"/> No <input type="checkbox"/>	Hep B / Hep C: (please circle)
HIV/AIDS Yes: <input type="checkbox"/> No <input type="checkbox"/>	Heart Failure/ Heart Condition: Yes <input type="checkbox"/> No <input type="checkbox"/>
Acquired Brain Injury (e.g., concussion, blow to the head from fight, sports, motor vehicle accident): Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," did this involve a loss of consciousness? Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Issues: Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Pain: Yes <input type="checkbox"/> No <input type="checkbox"/>	Mobility Issues: Yes <input type="checkbox"/> No <input type="checkbox"/>
Learning Disability Yes <input type="checkbox"/> No <input type="checkbox"/>	Injuries/ Accidents Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy/ Seizure Disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever been diagnosed with insomnia or other sleep disorder, such as sleep apnea or nightmares? Yes <input type="checkbox"/> No <input type="checkbox"/>

If "YES" to any of the above Health Assessment questions, please explain how long you have had the condition and what your current treatment involves (e.g., medication, regular monitoring):

SAFETY CONCERNS

Have you EVER HAD suicidal thoughts? Yes No

Are you CURRENTLY having suicidal thoughts? Yes No

Have you in the PAST 3 MONTHS? Yes No

Were you USING ALCOHOL OR DRUGS at the time of the suicidal thoughts? Yes No

Have you EVER ATTEMPTED Suicide? Yes No

Have you ATTEMPTED Suicide in the PAST 3 MONTHS? Yes No

Did you require ANY MEDICAL ATTENTION, such as an Emergency Room Hospital visit? Yes No

Were you USING ALCOHOL OR DRUGS at the time of the suicide attempt? Yes No

Do you currently engage in SELF-HARM BEHAVIOR (such as cutting)? Yes No

Have you engaged in SELF-HARM IN THE PAST 3 MONTHS? Yes No

Were you USING ALCOHOL OR DRUGS at the time of the self-harm? Yes No

Did you REQUIRE ANY MEDICAL ATTENTION, such as an Emergency Hospital visit? Yes No

Please give us any FURTHER DETAILS to any of the above situations, such as how, when, how many times, etc.:

PHYSICIAN INFORMATION

Name of Family Practice/General Practice Physician:

Address:

Phone Number:

Fax Number:

MEDICATIONS, VITAMINS AND SUPPLEMENTS (All Prescribed and Over the Counter) <i>Please give a detailed list of your current medications</i>					
Medication Name	Dosage (mg)	How often?	Time of Day Taken	Is it PRN (as needed)?	Why do you take this medication?
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
<p>Please read the following: Clients are asked to arrive at the ranch WITH CURRENT, VALID, PRESCRIPTIONS FROM THEIR PHYSICIAN with refills available for at least 30 days. Alternatively, prescriptions held at a client's home pharmacy, can be transferred electronically to the Top of the World Ranch's pharmacy upon request. If a client arrives to the Ranch with neither of these options for prescription medications, a renewal will need to be discussed at a visit with our Ranch Physician.</p> <p>I have read and understand and agree to the above. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>If you require further explanation of the above, please do not hesitate to ask Ranch staff prior to attending treatment.</i></p> <p>Please read the following: For safety reasons, all over the counter medications or herbal supplements must be approved for use by our Ranch Physician. Please limit all supplements to those that you feel are NEEDED rather than DESIRED. Unless there is a medically necessary reason stated by a licensed physician, we will limit the number of herbal supplements to 4 (four). We will require a medical note.</p> <p>I have read and understand the above requirement. Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
Pharmacy:			Phone #:		
Pharmacy Location:					

ALLERGIES/ DIETARY		
Food Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>	Any Other Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>
If "YES" to any of the above, please explain in detail, including any serious reactions that you have had in the past to these allergies:		
Please describe any Dietary Restrictions we should know about? (i.e., Vegetarian/Vegan/Lactose Intolerant/Sodium Controlled Diet):		
Please describe any dietary Religious Restrictions we should be aware of:		
TB SCREENING		
Our licensing body (Interior Health Authority) requires that all clients in residential treatment have a current TB test. As part of the acceptance process, we require that you provide us with the results of your test before you are admitted. Do you have TB test results that are less than 4 years old? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Chronic Cough (+ 2 weeks): Yes <input type="checkbox"/> No <input type="checkbox"/>	First Nations AND on Reserve: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Productive Cough (mucus/phlegm): Yes <input type="checkbox"/> No <input type="checkbox"/>	Recent or Past Exposure to TB (Circle one)	
Bloody Sputum (hemoptysis): Yes <input type="checkbox"/> No <input type="checkbox"/>	Previous Active TB with Treatment: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Rapid 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"/>	History of Birth/ Travel to Countries with high rates of TB: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Fever (often low grade): Yes <input type="checkbox"/> No <input type="checkbox"/>	History of Correctional Institution or Long-Term Care Facility: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Feelings of Fatigue: Yes <input type="checkbox"/> No <input type="checkbox"/>	History of or current Intravenous Drug Use/IV Substance Abuse: Yes <input type="checkbox"/> No <input type="checkbox"/>	
IMMUNIZATION HISTORY		
To the best of your knowledge, are you?		
Fully Immunized: Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had an adverse reaction to a vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Immunized as a child: Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes to adverse reaction, please explain:
Immunized through work: Yes <input type="checkbox"/> No <input type="checkbox"/>	Immunized for travel: Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you receive the Flu vaccine this year? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you interested in receiving the Flu vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/>
INTENSIVE RESIDENTIAL TREATMENT READINESS	
Have you ever been formally diagnosed by a mental health professional with a MENTAL HEALTH DISORDER OR CONCURRENT DISORDERS ? Yes <input type="checkbox"/> No <input type="checkbox"/> If "YES," please list your diagnosis and approximate date of diagnosis:	Do you have any concerns about? 1. Feeling DEPRESSED, SAD , lacking energy or lacking enjoyment in life? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Feeling NERVOUS, ANXIOUS OR AGITATED ? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Quality of, or amount of SLEEP ? Yes <input type="checkbox"/> No <input type="checkbox"/>
ANOREXIA: Yes <input type="checkbox"/> No <input type="checkbox"/> Current/Past (Please circle one) If "YES," is this only present while you are actively using? Yes <input type="checkbox"/> No <input type="checkbox"/>	BULIMIA: Yes <input type="checkbox"/> No <input type="checkbox"/> Current/Past (Please circle one) If "YES," is this only present while you are actively using? Yes <input type="checkbox"/> No <input type="checkbox"/>
Any BINGE OR PURGE EATING BEHAVIORS that do not meet criteria for an Eating Disorder? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever been EXPOSED TO A NATURAL DISASTER , such as a hurricane, flooding, fire, or an earthquake? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have history of PHYSICAL ABUSE OR TRAUMA ? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have history of SEXUAL ABUSE OR TRAUMA ? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a history of having been exposed to DOMESTIC VIOLENCE ? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you been the VICTIM OF OR WITNESSED A VIOLENT CRIME ? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you grow up in a NEIGHBORHOOD that was characterized by VIOLENCE OR CRIMINAL BEHAVIOR ? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you been the VICTIM OF BULLYING (including cyber bullying) or threatening behavior? Yes <input type="checkbox"/> No <input type="checkbox"/>
MENTAL HEALTH COUNSELLING HISTORY	
In the PAST have you participated in counseling, psychological or psychiatric services? Yes <input type="checkbox"/> No <input type="checkbox"/>	
How long ago?	For how long?

What were your GOALS in the past while you attended, and what was MOST HELPFUL?

Please provide the NAME AND CONTACT INFORMATION for your previous mental health counselor(s) (include address and phone number):

Are you CURRENTLY in counselling? Yes No

If "YES," what are your GOALS, and what has been MOST HELPFUL?

May we contact these Providers? Yes No

(Note: this requires a separate Release of Information to be completed), attached below.

If "YES," please provide NAME AND CONTACT INFORMATION for your current mental health counselor, including phone number:

PREVIOUS/CURRENT SUBSTANCE ABUSE TREATMENT EXPERIENCE

Have you previously attended a Substance Abuse Treatment Program? Yes No

If "YES" was it:

Outpatient Residential

May we contact these Providers? Yes No

(Note: this requires a separate Release of Information to be completed), attached below.

Did you complete the program? Yes No
If "NO," please explain.

Date(s):

Name of Treatment Program(s):

Contact Information (including phone number):

What were your GOALS while you attended and what was MOST HELPFUL?

PARTICIPATION IN 12-STEP, SMART RECOVERY, OR DHARMA/REFUGE RECOVERY PROGRAMS

Are you currently participating in a 12-STEP FELLOWSHIP? Yes No

For those participating in a 12-Step Fellowship, do you HAVE A SPONSOR? Yes No

If "YES," for how long?

Do you SPONSOR ANYONE? Yes No

Are you currently active (e.g., regular weekly attendance) Yes No

If "YES," for how long?

Have you WORKED ALL 12 STEPS? Yes No

If "YES," how many times?

Do you or have you performed SERVICE WORK? Yes No

Do you have a homegroup? Yes No

If "YES," please provide details (e.g., the name, days of the week):

Do you or have you participate(d) in SMART RECOVERY? Yes No

Are you CURRENTLY ACTIVE (e.g., regular weekly attendance) Yes No

If "YES," for how long?

If "YES," have you WORKED ALL OF THE TOOLS (e.g., ABC, USA, CBA, etc.)? Yes No

Do you or have you participate(d) in REFUGE/DHARMA RECOVERY? Yes No

Are you **CURRENTLY ACTIVE** (e.g., regular weekly attendance) Yes No

If "YES," for how long?

If "YES," have you **WORKED THE 8-FOLD PROGRAM** Yes No

CLIENT READINESS TO CHANGE QUESTIONS

What are your **PERSONAL GOALS** for treatment here at the Ranch? What changes do you want to make in your life?

On a scale of 1 to 10 (1 being *not at all* and 10 being *extremely*), **HOW IMPORTANT** is it to you that you make these changes?

On a scale of 1 to 10 (1 being *not at all* and 10 being *extremely*), **HOW CONFIDENT** are you that you can make these changes?

What do you feel may be **CHALLENGES** during your stay at treatment?

How can we work with you to **MINIMIZE THESE CHALLENGES**?

Is there **ANYTHING ELSE THAT WE SHOULD KNOW ABOUT YOU** that might help us better work with you?

IF TOP OF THE WORLD RANCH STAFF HAVE COMPLETED THIS APPLICATION:

Staff Name:



**Top of the World Ranch Treatment Centre (TOWR)
Consent to Release and/or Receive Health Information**

8350 Holmes Road, Fort Steele B.C. V0B 1N0

Toll Free 1-888-996-6306

Phone 250-426-6306 Fax 250-426-6377

www.ranchrecovery.com

I, _____ / _____

(Printed Name of Client)

(Date of Birth)

- Agree to **RELEASE** the below identified information (check all that apply):
- Assessment/Treatment Summaries, including discharge/continuing care recommendations.
 - Medical Information, including diagnosis and medication information.
 - Attendance and Progress in Treatment.
 - Other (specify): _____
- Agree to **REQUEST** the below identified information (check all that apply):
- Assessment/Treatment Summaries, including discharge/continuing care recommendations.
 - Medical Information, including diagnosis and medication information.
 - Attendance and Progress in Treatment.
 - Other (specify): _____

Purpose of disclosure: _____

The individual/organization that TOWR is authorizing to **RELEASE TO** **REQUEST FROM:**

Name of Individual/Organization: _____

Address: _____ **City/Town:** _____

Phone: _____ **Fax:** _____

Province: _____ **Postal Code:** _____

Method of Release of Information: Please check all boxes that apply and those that are deemed an acceptable release of information method(s). Initial your selection(s).

- By Phone (consults only – not for written purposes).
- By E-Mail (I understand that confidentiality cannot be guaranteed if this form of communication is used).
- By Fax. By Mail.

Date (MM/DD/YYYY) _____ **Client Signature** _____

Parent/Guardian Name, If Required (Printed) **Parent/Guardian, If Required (Signature)**

I authorize Top of the World Ranch Treatment Centre to disclose the client's health information described above to the individual or organization identified above. I understand why I have been asked to disclose my health information and I am aware of the risks and benefits of consenting to or refusing to consent. I understand I may revoke this consent verbally or in writing at any time by giving notice to the Top of the World Ranch Treatment Centre office. This consent is valid for 180 days from the date of signature.