Peguis Al-Care Treatment Centre Inc.
P.O. Box 69
Peguis, Manitoba
ROC 3JO
Telephone: (204)645-2666
Fax: (204)645-2216
Toll Free #: 1-877-645-2666

Greetings

Whether this package is for yourself, a family member, loved one, employee, community member or client, we thank you for considering joining us at the Peguis Al-Care Treatment Centre.

This referral package will assist in assessing and admission into either our residential or day treatment program. We offer a six (6), seven (7), eight (8) or nine (9) week residential program, and a three (3) or four (4) week day program. Our programs are offered to those individuals 18 years of age or older and our programs are co-ed.

The Peguis Al-Care Treatment Centre is a twenty bed facility and we are located north of Winnipeg, Manitoba off Highway 7. Our centre location is on the Peguis First Nation Reserve, which is a two hour drive north of Winnipeg, Manitoba. Peguis First Nation is known as the Sweet Grass capital of Manitoba and our centre is nested in the heart of the reserve.

At the Peguis Al-Care Treatment Centre we treat the body, mind and spirit as we work towards enhancing our clients' recovery, personal growth and development. Our program is unique as we offer traditional teachings, as part of our programming. This program is intended to enhance rather than replace any of the clients' present beliefs. Those individuals who attend our centre will be introduced to a number of programs that we offer, as we currently offer over twenty. These programs are intended to provide the individuals with information and basic life skill tools, which they can utilize in their lives.

The Peguis Al-Care Treatment Centre Staff are fully trained, certified and professional. Our centre is a recognized facility with Accreditation status.

Taking the step to enter a treatment program and receive help with an addiction will be one of the most important and difficult decisions one has to make in their life. The staff at the Peguis Al-Care Treatment Centre look forward to assisting the individuals as they prepare to venture on a new, positive journey in their lives.

PRE-ADMISSION CHECKLIST

(Referring agent must review with client)

Please feel free to contact the Intake Worker if you have any questions or need clarification on anything.

WHAT TO BRING

- ☐ Provincial Health Card
- ☐ Photo Identification ie: Driver's License, Status Card
- ☐ Calling Card / Phone Card (also available at Peguis store)

Note: Women are asked to bring long skirts for traditional use.
Men are asked to bring shorts for sweat lodge use.
The traditional teachings are part of the program.
(Clients decision to/or not to partake in the sweats is a decision only they will make).

Personal Hygiene

Bring enough for your 6-9 week stay.

- ☐ Shampoo/Conditioner
- ☐ Deodorant
- ☐ Sanitary Products
- ☐ Toothbrush/Toothpaste
- ☐ Shaving Cream/Razors
- ☐ Soap
- ☐ Brush/Comb
- ☐ Towels/Facecloths

Note: Items with any alcohol content (hairspray, mouthwash,etc.) will be placed in a locked storage area.

Clothing

Clothing should be suitable for seasonal weather.
Note: Laundry facilities available and laundry soap is provided.

- ☐ Pants
- ☐ Shirts
- ☐ Underwear
- ☐ Socks
- ☐ Coat/Jacket
- ☐ Outdoor Clothing
- ☐ Shoes/Boots
- ☐ Indoor Slippers/Shoes
- ☐ Pyjamas/ sleepwear
- ☐ Outdoor Clothing (snow pants, gloves, toques, winter boots, etc.)

Personal Items

- ☐ Tobacco (for traditional use)
- ☐ Cigarettes
- ☐ Money (for personal use)
- ☐ Spiritual / Religious Items
- ☐ Musical Instruments
- ☐ Personal Craft Supplies

THINGS NOT TO BRING:

- ☐ Headphones
- ☐ Suggestive/revealing Clothing
- ☐ Drug Paraphernalia
- ☐ Cameras or video equipment
- ☐ Heating Pads or electric blankets
- ☐ Weapons, including pocket knives
- ☐ Valuable jewelry or expensive clothing

MISCELLANEOUS INFORMATION

Prescription Medication:

All medication must be prescribed by a physician. **All Prescribed medication must be faxed to Grand Medicine Pharmacy.** Grand Medicine Pharmacy phone #: (204) 372-6048, Fax #: (204) 372-6469. The Drug information sheet for all medication must also be brought in. Please arrange this with your doctor to fax to Grand Medicine Pharmacy. Please ensure you have enough medication for your **36/56** or **42/56 day** stay. All your medications will be delivered at the time of your admission. It is your responsibility to ensure your medication is taken when needed.

Luggage Check:

Please be advised that when you arrive at the centre there will be a luggage/personal inventory check. Items not allowed ie: cell phones, electronic devices, etc. , will be placed in your personal locker, in a secured area, and will be returned to you upon discharge.

Traditional Land Based Healing Component:

As part of your treatment program, you will be attending a camp for 3 days. Please ensure that you bring appropriate clothing and footwear for this outing. This is a requirement for all clients to attend.

Mail:

The mailing address for letters and packages is: *Client's Name,* c/o Peguis Al-Care Treatment Centre, Box 69, Peguis, Manitoba, ROC 3JO.
All mail will be recorded and checked, prior to it being forwarded to the client.

Pre-Treatment Requirements Checklist

(Referring agent to complete with client)

In order for the whole intake process to run smoothly, promptly and to ensure that the client is a good fit for the program, the checklist must be fully completed and returned to the intake worker, prior to the client admission.

- ☐ Referral Form & Assessment - fully and thoroughly completed
- ☐ Consent to Attend & Participate in Treatment
- ☐ Pre-treatment Assessment
- ☐ Referral Agent's Summary
- ☐ Consent for the Release of Information
- ☐ Client Release of Liability
- ☐ Consent for Release of Medical Information
- ☐ Medical Assessment - To be completed by a MD or RN.
- ☐ Tuberculosis Screening
- ☐ Mental Health Assessment is required (if client has answered yes to Self Harm/Suicidal Ideations).

Referring Agent is responsible to ensure that the client is aware that they are responsible for their own transportation, if they are discharged or self discharged.

- ☐ Client Informed

Referring Agent ensured your client has taken care of all personal, medical, financial, legal, CFS matters and family visits, prior to attending the centre.

- ☐ Yes

Upon arrival to the Centre, the client will:

- ⇒ Be welcomed by staff.
- ⇒ Taken to kitchen and offered a snack and drink.
- ⇒ Have the orientation check list completed.
- ⇒ If any medication is brought in, it will need to be recorded onto a Medication Management form and is to be placed in the client locker, which will be reviewed and taken care of by the Intake Worker.
- ⇒ Have all toiletries (hair spray, nail polish, after shave, mouth wash, cologne, body sprays, etc.) recorded and placed in a private locker, which will be available for use, when needed.
- ⇒ Complete all admission forms.
- ⇒ Be given the client handbook, plus the client orientation binder, which outlines the guidelines, code of conduct, visiting hours and other important information.
- ⇒ Be shown their room which will have all their bedding supplies already in their room.
- ⇒ Be introduced to the other clients.
- ⇒ Be given a tour of the centre.
- ⇒ Be given the time and opportunity to freshen up, rest and settle into the centre.

Admission Agreement

⇒ I understand that if I arrive intoxicated or high on any substances that, I will not be admitted to the PATC - and the proper authorities will be notified.

⇒ I understand that an incomplete application package, including the supporting documents (medical) can delay the processing of my application and confirmation, including an intake date.

⇒ I consent to the Intake worker contacting referral agencies (doctors, probation services, NNADAP) to obtain information or clarification on the information in this application form.

⇒ I understand that if I have any outstanding legal issues, pending court dates, or CFS matters, that they must be dealt with prior to admission to the program and that any meetings, court issues, etc., must be arranged for after completion of the program.

⇒ I understand that the Intake worker or Counsellor will contact my referral agent and send a letter confirming my acceptance, start date for treatment, progress reports upon request, and a program completion report.

⇒ While in treatment, I understand that if I need any urgent medical attention, I will be transferred to an appropriate facility.

⇒ I understand that if I am discharged or voluntarily leave treatment, that I am responsible for my own travel arrangements.

⇒ I understand that treatment has various components, ie: A.A, Traditional Teachings, Land Based Healing, that I am coming prepared to fully participate in these and all the treatment components.

⇒ I understand that it is important to be free from all outside business and responsibilities that may take my focus away from my treatment program.

⇒ I understand that the treatment centre has general daily living guidelines, responsibilities, chores and a code of conduct that are to be adhered to, followed and respected at all times.

⇒ I understand that I will have no access to phones for the first week in treatment and that phone access is allowed, but that it will be limited (time limit and days), and only clients who have calling cards will be allowed to use the phone.

⇒ I understand that there are **absolutely no** cell phones, iPod, digital cameras, earplugs or any electronic devices allowed while in treatment.

I have fully read and reviewed this Admission Agreement. I fully agree to the terms and conditions and fully consent to attending the 6/7/8/9 (six/seven/eight/nine) week program at the Peguis Al-Care Treatment Centre.

_____

(Print Client Full Name)

_____ _____

Client Signature Date

_____ _____

Referral Agent's Signature Date

*Please print Legibly & Clearly

Peguis Al-Care Treatment Centre

Application Date: ____/____/____/
Day Month Year

Applying For: Residential ☐
Day ☐

Intake/Application Package

Last Name (Legal): _____ First Name: _____ Middle Name: _____
(Please Print) (Please Print) (Please Print)

Preferred Name: _____ Date of Birth: _____/ _____/ _____
Day Month Year

Male ☐ Female ☐ Two Spirited/Transgender Yes ☐ No ☐

Address: _____
Box No. Community Province Postal Code

Status ☐ Non-Status ☐ Bill C-31 ☐ Inuit ☐ Other _____

Band Name: _____ Treaty # (10 digits): _____

S.I.N. _____

MB. Family Health # (6 digits): _____ MB. Personal Health # (9 digits):_____

Ontario Health #: _____ Other Health #: _____

Home Telephone #: (____) _____ Cell #: (____) _____

Marital Status: Single ☐ Married ☐ Common-Law ☐ Widowed ☐ Divorced ☐ Separated ☐

If separated, how long? _____

Reason for separation? _____

_____

Emergency Contact: _____ Relationship: _____

Address: _____ Telephone #: (____)_____

_____

Referring Agent's Name: _____

Title: _____

Telephone #: (____)_____ Fax #: (_____)_____

Address: _____

Email: _____

Personal

1. Was the client raised on reserve? Yes ☐ No ☐

2. Was the client raised by his/her birth parents? Yes ☐ No ☐

3. Has the client stated that addictions are a problem in his/her life? Yes ☐ No ☐

4. Has the client stated or acknowledged that sobriety is needed in order to change? Yes ☐ No ☐

5. Are certain areas of the client's life affected by their substance abuse? Yes ☐ No ☐

6. Has there been a death in the family due to substance abuse? Yes ☐ No ☐

7. Did the client attend residential school? Yes ☐ No ☐

8. Number of children: _____ At Home _____ In Temp Care _____ In Perm Care ____ Other_____

9. Are you involved with Child & Family Services? Yes ☐ No ☐

If so, who is the contact person/worker?

_____

Name of worker | Community | Box No. | Province | Postal Code | Telephone No.

10. Does client have any concerns regarding the safety of children at home? Yes ☐ No ☐

11. Do any of the following apply to your (client) childhood? (Check all that apply)

Alcohol/Drug abuse	☐	Witness to domestic violence	☐
Unhappy home life	☐	Suicide death of family member/close friend	☐
Sexually abused	☐	Divorce/separation of parents	☐
Physically abused	☐	Emotionally abused	☐

Employment/Occupation

Is client: Self Employed ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temporary ☐

Student ☐ Retired ☐ Homemaker ☐ Job Training ☐ Income Assistance ☐

Employment/Occupation

_____

Name of workplace | Community | Job Title

Education

Client has Grade _____ Upgrading ☐ College ☐ University ☐ Trade School ☐ Adult Education ☐

Client can: Read Yes ☐ No ☐ Write Yes ☐ No ☐

Language

Spoken English ☐ Ojibway ☐ Cree ☐ Other ☐

Understands English ☐ Ojibway ☐ Cree ☐ Other ☐

Diet

Food Allergies: Yes ☐ No ☐ If so, please list _____

Eating Disorders: Yes ☐ No ☐ Explain _____

Special Diet: Yes ☐ No ☐ Explain _____

Does client eat traditional foods? Yes ☐ No ☐

If not, is client willing to try? Yes ☐ No ☐

Spiritual /Traditional

Is the client involved in any spiritual /traditional activities? Yes ☐ No ☐

Is the client aware that our centre provides a unique traditional program? Yes ☐ No ☐

Is the client ready and willing to participate in the spiritual/traditional components of the program? Yes ☐ No ☐
(ie: Land Based Healing, Sweats, Prayers, talking circles, church, smudging, medicine picking, etc.)

Treatment History

Has the client attended a treatment centre in the past? Yes ☐ No ☐

Treatment Centre Attended	Date Attended	Reason for Attending	Completed or reason for leaving	Length of Abstaining

History of Substance/Drug Abuse

Type Note: Put a circle around primary drug (s) of choice	**None**	**Rarely**	**Monthly**	**Weekly**	**Daily**	**Amount/ Quantity**	**Age of First Use**	**Date of Last Use M/D/Y**
Alcohol (beer, wine, hard liquor, home brew, etc.)								
Marijuana, Hashish								
Inhalants (glue, paint), sprays, solvents, gas								
Cocaine (e.g. crack, coke)								
Stimulants/Amphetamines								
Opiates – Morphine, Heroin, Dilaudid								
Tranquilizers – Ativan, Valium, Librium, Zanax								
Hallucinogen- LSD, PCP, Dust, Mushrooms								
Painkillers – Codeine, Perdocan, Lalwin								
Crystal Meth								
Tobacco - Other								
Prescription Drugs (e.g. T3's, etc)								
Over the counter Drugs								

Substance/Drug Abuse /Mental Health History

1. Has client ever had:

D.T's Yes ☐ No ☐

Blackouts Yes ☐ No ☐

Seizures Yes ☐ No ☐

Hallucinations Yes ☐ No ☐

Withdrawal Symptoms Yes ☐ No ☐

2. Have you ever behaved in a violent manner when you were under the influence of any substances? Yes ☐ No ☐

3. Have you ever over-dosed on any drugs, alcohol or prescribed medication? Yes ☐ No ☐

4. If "Yes" was the over-dose: Accidental ☐ Intentional ☐

5. Have you over-dosed in the past? Yes ☐ No ☐

6. Have you ever thought of committing suicide? Yes ☐ No ☐

7. Have you ever attempted suicide? Yes ☐ No ☐ If "Yes" how many times? _____

8. Were you ever hospitalized as a result of your suicide attempt? Yes ☐ No ☐

9. Were you under the influence of alcohol and/or drugs, at the time of your last suicide attempt? Yes ☐ No ☐

10. Have you ever talked with anyone about your suicide attempt(s)? Yes ☐ No ☐

11. Are you presently thinking about hurting yourself or attempting suicide? Yes ☐ No ☐

12. Has client ever inflicted self harm (ie: cutting)? Yes ☐ No ☐

* Note: Any client answered "Yes" to suicidal ideation, a Mental Health Assessment Letter will be required.

Medical/Physical/ Psychological History

1. Does client have any significant medical issues or disabilities that we should be aware of? Yes ☐ No ☐

If "Yes", please explain. _____

2. Is client pregnant? Yes ☐ No ☐ If "Yes", how many months into pregnancy? _____

3. Does client have any physical limitations? Yes ☐ No ☐

If "Yes", please explain. _____

4. Has the client ever met with a psychiatrist or mental health worker? Yes ☐ No ☐

5. Name of person you were seeing, address and phone number.

_____

6. When did client start seeing the individual? _____

7. Is client still seeing the individual? Yes No ☐

If "No", please indicate reason for stopping. _____

8. If client is on medication, List all medication, what medication is for and how long the client has been on the medication.

_____

_____

_____

Please indicate if you have had to deal with any of the following issues in the past 12 months.

Employment Issues ☐ Anger/Violent Outbursts ☐ Custody Issues ☐ Self Harm ☐

Apprehension of Children ☐ Grief/Loss ☐ Family Violence/Abuse ☐ Suicide ☐

Depression ☐ Lack of Support ☐ Miscarriage ☐ Interrupted Pregnancy ☐

Sexual Abuse/Rape ☐ Separation/Divorce ☐ Problematic Gambling ☐ Drugs ☐

Alcohol ☐ Prescription Drugs ☐ Medical Issues ☐ Psychological Issues ☐

Legal

Note: The Centre requires all client legal documents (ie: Probation Order)

1. Does client have any *past* legal issues? Yes ☐ No ☐

   If "Yes", please explain: _____

2. Does client have any *present* legal issues? Yes ☐ No ☐

   If "Yes", please explain: _____

3. Has client been released on a recognizance/probation/parole? Yes ☐ No ☐

4. Is client on a conditional or temporary release? Yes ☐ No ☐

5. Does client have any upcoming court dates? Yes ☐ No ☐

   If "Yes", please explain charges: _____

6. Has client dealt with all *immediate* legal issues/appointments prior to coming into the centre? Yes ☐ No ☐

Telehealth

1. Does client have telehealth available in his/her home community? Yes ☐ No ☐

2. Would the client be requesting telehealth for family visits, while in the centre? Yes ☐ No ☐

3. Would telehealth be requested for the client graduation? Yes ☐ No ☐

Support

1. How does your partner and family members feel/react to your coming into the centre?

   _____

   _____

2. What type of pressures/difficulties did the client experience, prior to coming into the centre?

   _____

   _____

3. Will the client have any support while in treatment? Yes ☐ No ☐

   If "Yes", please list the supports: _____

   _____

Peguis Al-Care Treatment Centre

Medical History

Entrance to the PATC requires a comprehensive medical check-up.

This Medical History must be completed & Signed by a Dr. RN. or a LPN.

Client Name: _____

D.O.B.: _____

Band & Treaty #: _____

Name of Dr./R.N./LPN.: _____

Address: _____

Postal Code: _____ Fax: _____

Telephone #: _____ **Signature**: _____

Please indicate if the client had or has any history of the following:
(Please check off only those that apply)

Diabetes ☐ Asthma/COPD ☐ High Blood Pressure ☐

High Cholesterol ☐ Heart Disease/Stroke ☐ Pregnancy (LNMP) ☐

Anxiety ☐ Panic Disorder ☐ Depression ☐ Teeth/Dental ☐

Suicide (Attempted) ☐ Suicide Ideation ☐ Epilepsy ☐ Problems with Nails ☐

Seizures ☐ Head Injury ☐ Skin Conditions ☐ Hepatitis/HIV ☐

Tuberculosis ☐ Scabies ☐ Lice ☐ Impetigo ☐

Problems with Ear, Nose, Throat ☐ Blood, Lymphatic System ☐ Cardio Vascular System ☐

Respiratory System ☐ Central Nervous System ☐ Sexually Transmitted Infections ☐

Conditions: Disabilities ☐ Physical ☐ Functional ☐ Cognitive ☐

If "Yes" to any of the above, please give details:

_____

_____

Would the client be capable of completing the 6-8 week treatment program? Yes ☐ No ☐

If "No", please explain: _____

_____

Are you aware of any current or recent medical conditions/problems which may or may not require follow-up while the client is in treatment?

Yes ☐ No ☐ If "Yes", please explain: _____

The following should be completed **PRIOR** to the client attending treatment:
(Please check off all that have been explained and are applicable to the client)

Medical Appointments ☐ Dental Appointments ☐ Prenatal Appointments ☐ Pregnancy Test ☐ Head Lice Check ☐

Peguis Al-Care Treatment Centre

Medical Assessment

(This Medical Assessment is to be completed & signed by a Dr., RN. or LPN.)

Client Personal Identification

First Name: _____ **Last Name**: _____

Middle Name: _____

Birthdate: Day _____ Month _____ Year_____ Age: _____

Gender: Male ☐ Female ☐

MB. Family Health # (6 digits): _____ MB. Personal Health # (9 digits): _____

Ontario Health #: _____

Treaty Number: _____ Band: _____

Family Dr.: _____ Phone No: _____ Fax No: _____

Address: _____
Box No. Community Province Postal Code

Pharmacist: _____ Phone No: _____ Fax No: _____

Address: _____
Box No. Community Province Postal Code

Informed Consent Must Be Completed With Client

I, _____ do hereby request and give permission to Physician/Registered Nurse,
Please Print-Full Name of Client
to release my medical information and assessments to the Peguis Al-Care Treatment Center. The photocopy of my signature on this form is considered as valid as the original.

Client Signature: _____ Date: _____

Note: To the Physician/Registered Nurse

The above client is to be medically assessed as a potential client/participant in our 6/7/8/9 week residential alcohol and drug treatment program or 3/4 week Day Program. Our program is designed to assist individuals to recognize how their drinking/drug use has affected their lifestyles and to support and encourage them to make sound and decisive choices and changes in their lives.

The Peguis Al-Care Treatment Centre ***requires*** that the potential client have a ***complete*** physical examination prior to their admission into the centre.

The client should not require any acute medical care, at the time of admission to the Peguis Al-Care Treatment Centre. Any/all communicable diseases are to be fully treated and under control, prior to admission to the Centre.

Signature of Dr./R.N./LPN: _____

Date: _____

Tuberculosis Screening

(Part A to be completed by the client)

As a prerequisite before participating in the Residential/Day treatment program, all clients will be asked the following Tuberculosis (TB) screening questions for signs of Tuberculosis (TB):

PART A: All Tuberculosis Screening Questions are to be completed.

1.	Changing or prolonged cough.	Yes ☐ No ☐
2.	Sputum increase with or without blood tinges.	Yes ☐ No ☐
3.	Extreme tiredness.	Yes ☐ No ☐
4.	Loss of appetite.	Yes ☐ No ☐
5.	Loss of weight.	Yes ☐ No ☐
6.	Night sweats.	Yes ☐ No ☐
7.	Fever/chills.	Yes ☐ No ☐

If you have answered "No" to all of the above questions, then the TB test ***does not*** have to be done.

If you have answered "Yes" to 1 or more of the questions, then ***you must*** have a TB test done immediately and you must have a physician or Registered Nurse complete the following - Part B.

(Part B to be completed by a Physician/Registered Nurse or LPN)

PART B: Tuberculosis Test

Date of Test: _____

Results: Negative ☐ Positive ☐

Chest X-ray (if applicable): Yes ☐ No ☐ Results: _____

Prophylaxis (if applicable): Yes ☐ No ☐ Date Started: _____

Comments:

_____

_____

_____

Name: _____
(Physician/RN/LPN)

Address: _____
City: _____
Province: _____
Postal Code: _____
Telephone: _____
Fax #: _____

Office Stamp

Signature: _____
(Physician/ RN/LPN)

Consent for the Release of Information

I, _____, hereby give permission for PATC staff to contact
(Client's Full Name)

_____ for the release of information relating to the pre-treatment
(Referral Agent's Name)

conference call, progress reports, aftercare planning and final discharge report.

Referral Agent's Name: _____ Title: _____

Organization: _____

Address: _____
Box No. Community Province Postal Code

Phone Number: _____ Fax Number: _____

This consent is applicable for one year after the date signed.

_____ _____
Client's Signature Date

Client Release of Liability
Assumption of Risk Agreement
**** Read before Signing****

Treatment Centre Name: Peguis Al-Care Treatment Centre

Client's Full Name: _____
(Print Name)

In consideration of being allowed to participate in any way in the program, related events and activities, I, the undersigned, acknowledge, understand and agree that:

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, *HEREBY RELEASE, INDEMNIFY, AND HOLD HARMLESS* Peguis Al-Care Treatment Centre Inc., its members, officers, agents and/or employees, directors, supervisors and board members, from any and all claims, demands, losses and liability arising out of or related to any *INJURY*, *DISABILITY OR DEATH* I may suffer, or loss or damage to person or property, *WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE*, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND IT'S TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

_____ _____
Client's Signature Date

Client Code of Conduct

The following Code of Conduct is necessary for the safety of clients and staff to ensure a successful treatment cycle. All treatment participants (clients) are expected to abide by and observe the Code of Conduct:

Critical Conduct –Violation will result in Immediate Discharge:
Failure to comply with the following Code of Conduct will result in immediate dismissal from PATC (Peguis Al-Care Treatment Centre) program. Client being discharged or self-discharged will be responsible for own travel arrangements.

1. Suspicion of alcohol/mind altering substances, prescription medication abuse, and paraphernalia, while in treatment or upon admission
2. Display of angry outbursts, verbal abuse, accusations or harassment towards clients or staff will not be tolerated. Any physical violence or uttering of threats can lead to criminal charges. Absolutely no bullying.
3. Suspicion of sexual and intimate relationships between clients & clients; clients & visitors; clients and staff are strictly prohibited.
4. Damaging the property of the PATC (i.e. writing on walls, tables, lamps, books, etc…) or the personal property of others may lead to charges. Client is liable to pay for damages.
5. Continue to break the Code of Conduct.
6. Unreasonable refusals to actively participate in traditional or spiritual aspect and all activities of the PATC program.
7. Any illegal activities during client outings or in house will not be tolerated; legal authority will be involved.

Critical Conduct – Potential Discharge: Client being discharged or self-discharged will be responsible for own travel arrangements.

1. Absolutely no going into other clients' room – this includes the adjoining room; keep to your own side.
2. All clients expected to do chores assigned to them, no exchanging chores. The list will be posted in the dining room and outside the office. Clients failing to do chores or complaining about chores is potential for discharge. Bribery or intimidation involving chores will not be tolerated.
3. All clients must attend all lectures and must stay in sessions for their entirety – no washroom or smoke breaks during sessions. Strictly no lateness or interruptions. Clients have to stay awake during all sessions.
4. Clients are not allowed to take other client's medication.
5. Clients are not allowed to wear clothing with insignias of alcohol, drugs, obscenities, improper language or sexual connotations that others may find offensive. This includes posters, cards, magazines and paraphernalia.
6. Client Warnings after 3 warnings if client still continues; client may be discharged.
7. Client who does not participate in PATC activities and display no effort to change your lifestyle. (Including morning check in, all group sessions and sharing circles)
8. Suspicion of electronics including cell phones while in treatment, client may be discharged.

Treatment Requirements & Expectations:

1. Clients have to stay within boundaries of the buildings – staff escort provided at all times. Code of Conduct & Guidelines includes all outings.
2. All clients must attend all outside meetings that are scheduled and all Tele-health meetings.
3. Clients should be aware of the PATC process especially regarding the Guidelines and Code of Conduct.
4. Saturday will be General Clean Up for client bedrooms and the building. Checklist will be posted on the bulletin boards.
5. Cleaning Equipment: such as mop, vacuum, etc. need to be placed back in the janitor room.
6. Clients are not allowed to ask staff/clients for cigarettes/tobacco or money. This includes visitors coming to the building. No borrowing or bribing allowed.
7. All clients must attend Graduation @ 12:00 p.m.

Client Owned Vehicle/PATC Vehicles

1. Car keys must be turned in on admission
2. Vehicles are strictly not used.
3. Absolutely no smoking in vehicles allowed
4. Clients must wear seatbelts while being transported

Visiting Hours

Visiting is permitted Three (3) times during your 8 week stay (arriving on a |Monday) and will be 2nd, 4th, and 6th Sunday (s) from 1:00 – 4:00 p.m. All Visitors are required to hand in all cell phones, wallets and purses upon arriving. Visitors are to abide by Visitor Guidelines. See Orientation Binder.

On the visiting Sunday **only**, clients who do not have visitors or tele-health visits are allowed to make phone calls. (Limit of 15 minutes) @ 5:00 p.m.

General Conduct

1. All medication, money and calling cards are to be handed into office upon admission and locked in medication room (inside client's individual lockers).
2. Clients are responsible for taking medication as required. All medication taken outside the general office door with staff present – both client & staff will initial that medication is taken in their medication chart. See Medication schedule times posted on office door.
3. No smoking allowed in the building only in designated area. Smoking Area will not be a hang out - for smoking only.
4. Staff rooms are off limits to clients. This includes the general office.
5. No bare feet allowed for safety and health reasons (indoor shoes recommended). Clients are encouraged to wear indoor shoes at all times.
6. Burning of sacred medicines done in the smudge room; (please remember to turn on light switch for the fan).
7. All staff has the authority to check all areas of the building at any time. This includes the bedrooms and outside areas. Routine checks also done throughout the night by the night shift staff.
8. The centre is also equipped with cameras which are located in various areas of the building. The night staff monitors the cameras throughout the night. The cameras can be played back to view specific dates and times.

Having had the General Guidelines and Code of Conduct explained, I understand and accept them; I agree to the following:

I understand that it is my right as an individual to:

a) Be treated with respect and honesty
b) Confidentiality within the limits of the law
c) Ask questions regarding treatment
d) Work with my counsellor on my own personal development

I also understand that as a client in treatment, I am responsible to:

a) Comply with all the PATC General Guidelines and Code of Conduct
b) Establish personal goals
c) Be on time for all sessions and take counselling seriously
d) Act in an appropriate manner while in PATC
e) Treat other clients and staff with respect and honesty

_____ _____

Client's Signature **Counsellor's Signature**

_____

Date

Client's Charter of Rights

The Client's Bill of Rights was developed to assert and promote the dignity and worth of all people who use services. The bill expresses the truth that clients are first and foremost human beings with the same rights as others.

- To be treated with dignity and respect.
- Have the right to be treated as a unique and valuable individual in a non-discriminatory manner.
- The right to begin dealing with my addiction and related issues in an environment that is safe and free of all forms of abuse.
- Have the right and responsibility, to question things that I do not understand or agree with.
- Have the right to accurate and complete information regarding the extent, nature and limitation of any service that is provided.
- The right to make a complaint about something that I do not agree with, or that makes me uncomfortable.
- Have the right to be free from all forms of sexual harassment.
- Have the right to withdraw from services at any time.
- To have one's cultural and spiritual needs met and respected.
- To have one's needs met in a professional and ethical manner.
- To express grievances and have them dealt with fairly.
- To privacy and the right to have my confidentiality protected and recognized.