Application to BLCS
Family Counselling Program

Beaver Lake
COUNSELLING

To be completed by Applicant(s) and Referring Worker.

ADULT APPLICANT #1
GENERAL INFORMATION

DATE OF APPLICATION:		
Last Name:	First Name:	
Marital Status: ❑ Married ❑ Common-Law ❑ Single ❑ Widow/widower ❑ Separated ❑ Co-Parenting ❑ Divorced		
Date of Birth (YY/MM/DD):	Home/Mobile Phone:	Work Phone:
Email:		
Mailing address:		
Aboriginal Ancestry: ❑ Yes ❑ No	Band Name:	❑ On Reserve ❑ Off Reserve
	Band Number:	
OHIP #:		
Emergency Contact:	Phone:	
Relationship to Applicant:		

EMPLOYMENT

Job:
Please select all that apply: ❑ Full time ❑ Part time ❑ Seasonal ❑ Other ______________

EDUCATION

Check all that apply:

❑ Elementary (Grades 1-8)	❑ College
❑ High School	❑ University
❑ High School Diploma	❑ Vocational: ______________
❑ Certificate: ______________	❑ Other: ______________

MEDICAL HEALTH

Check any known medical conditions and list prescribed medications and their dosage:

Prescribed Medication and Dosage

❑ Asthma ____________________

❑ Diabetes ____________________

❑ Epilepsy ____________________

❑ Seizures ____________________

❑ DT's ____________________

❑ Pregnant ____________________

❑ __________ ____________________

❑ __________ ____________________

MENTAL HEALTH

Are you currently experiencing:

Anxiety	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Flashbacks	❑ Yes	❑ No

Suicidal thoughts ❑ Yes ❑ No Have you attempted? ❑ Yes ❑ No Date: ____________

Have you ever been diagnosed with a mental illness? ❑ Yes ❑ No If "Yes", explain:

Are you concerned about violence in your life? ❑ Yes ❑ No If "Yes", explain:

REASON FOR REFERRAL

Why are you seeking counselling at this time?

What is the main concern (issue)?

How long has this been a problem?

What do you expect from the counselling process?

Beaver Lake
COUNSELLING

LEGAL STATUS

Are any current legal orders or probation in place?	❑ Yes ❑ No
Is receiving counselling a condition of probation?	❑ Yes ❑ No
Are there any pending charges or court dates in effect?	❑ Yes ❑ No
CONSENT: I give consent for my probation officer to release the above information to Beaver Lake Counselling Services. ❑ ______ (Initials) Probation Officer: ____________________ Phone Number: ________________________	

TREATMENT HISTORY

Have you received counselling in the past six months? ❑ Yes ❑ No

If "Yes", please explain.

Are you presently using mood-altering substances? ❑ Yes ❑ No

E.g., alcohol, street drugs, prescription drugs (not prescribed by your doctor)

If "Yes", please explain.

Have you been hospitalized because of substance misuse? ❑ Yes ❑ No

If "Yes", please list date(s)

Are you in a addiction treatment program? ❑ Yes ❑ No

❑ Suboxone ❑ Methadone ❑ Other ____________

Current dosage per day: _____________________

CONSENT: I give consent for my treatment program supervisor to release the above information to Beaver Lake Counselling Services. ❑ ______ (Initials)

Contact Person: ____________________ Phone Number: ________________________

Have you participated in a community-based:	Date	Program Completed
• substance abuse program ❑ Yes ❑ No Program Name ______________________________		❑ Yes ❑ No
• mental health program ❑ Yes ❑ No Program Name: ______________________________		❑ Yes ❑ No
• healing program ❑ Yes ❑ No Program Name: ______________________________		❑ Yes ❑ No
Have you participated in a residential treatment program?	**Date**	**Program Completed**
❑ Yes ❑ No Program Name: ______________________________		❑ Yes ❑ No

INFORMED CONSENT

I, (Applicant's Name, PLEASE PRINT) ______________________________, consent to attend BLCS and have reviewed the following points with my Referral Worker and initialed as confirmation of my understanding of the following points:

____1. I consent to BLCS contacting referral agencies listed in this application to obtain clarification on information included in this application.

____2. I understand that BLCS will record and store information regarding communication with the referring agency.

____3. I understand BLCS will notify my referral worker by letter to confirm my acceptance to treatment.

____4. If accepted, I consent for BLCS to discuss my progress and clarify any details with my referrer, if applicable.

____5. While in treatment, I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility and referrer will be notified.

____6. I understand it is my responsibility to be free from and have taken care of all outside business that would take my attention away from the treatment program.

Please do not schedule any major medical treatments during the program.

____7. I understand if I am discharged early or voluntarily leave treatment, I am responsible for my travel.

____8. I understand that abusing substances while in treatment may result in my immediate dismissal from the program, with recommendations to a different treatment program.

____9. I understand that BLCS staff engage in case conferencing for the benefit of treatment and healing.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, (Applicant's Name, PLEASE PRINT) ____, hereby give permission for BLCS staff to contact the referral worker(s) listed below for the release of information in regard to my application, process during treatment, aftercare planning, and final discharge report.

Referral Worker:	Organization/Agency:	Phone Number:
Alternate Contact Worker:	Organization/Agency:	Phone Number:

______________________________ ______________________________
Applicant's Signature Date

Beaver Lake
COUNSELLING

To be completed by Applicant(s) and Referring Worker.

ADULT APPLICANT #2 (if applicable)

GENERAL INFORMATION

DATE OF APPLICATION:			
Last Name:		First Name:	
Marital Status: ❑ Married ❑ Common-Law ❑ Single ❑ Widow/widower ❑ Separated ❑ Co-Parenting ❑ Divorced			
Date of Birth (YY/MM/DD):	Home/Mobile Phone:	Work Phone:	
Email:			
Mailing address:			
Aboriginal Ancestry: ❑ Yes ❑ No	Band Name:	❑ On Reserve	
	Band Number:	❑ Off Reserve	
OHIP #:			
Emergency Contact:		Phone:	
Relationship to Applicant:			

EMPLOYMENT

Job:
Please select all that apply: ❑ Full time ❑ Part time ❑ Seasonal ❑ Other ______________

EDUCATION

Check all that apply:

❑ Elementary (Grades 1-8)	❑ College
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Check any known medical conditions and list prescribed medications and their dosage:

Prescribed Medication and Dosage

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❑ Diabetes ______________________________

❑ Epilepsy ______________________________

❑ Seizures ______________________________

❑ DT's ______________________________

❑ Pregnant ______________________________

❑ __________ ______________________________

❑ __________ ______________________________

MENTAL HEALTH

Are you currently experiencing:

Anxiety ❑ Yes ❑ No

Depression ❑ Yes ❑ No

Flashbacks ❑ Yes ❑ No

Suicidal thoughts ❑ Yes ❑ No Have you attempted? ❑ Yes ❑ No Date: ______________

Have you ever been diagnosed with a mental illness? ❑ Yes ❑ No If "Yes", explain:

Are you concerned about violence in your life? ❑ Yes ❑ No If "Yes", explain:

REASON FOR REFERRAL

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If "Yes", please explain.

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❑ Suboxone ❑ Methadone ❑ Other ____________

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• mental health program ❑ Yes ❑ No Program Name: _______________________________		❑ Yes ❑ No
• healing program ❑ Yes ❑ No Program Name: _______________________________		❑ Yes ❑ No
Have you participated in a residential treatment program?	**Date**	**Program Completed**
❑ Yes ❑ No Program Name: _______________________________		❑ Yes ❑ No

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Alternate Contact Worker:	Organization/Agency:	Phone Number:

______________________________ ______________________________
Applicant's Signature Date

Beaver Lake
COUNSELLING

FAMILY INFORMATION

Child/Dependent First and Last Name	Date of Birth (yymmdd)	M or F (Gender)	Relationship to Applicant	Attending with Applicant?
1.				❑ Yes ❑ No
2.				❑ Yes ❑ No
3.				❑ Yes ❑ No
4.				❑ Yes ❑ No
5.				❑ Yes ❑ No
6.				❑ Yes ❑ No

Are these children living with you currently? ❑ Yes ❑ No	If Not, please explain.	Attach document(s): ❑ Service Plan ❑ N/A ❑ Safety Plan ❑ N/A

CONSENT: I give consent for my Child and Family service worker to release the above information to Beaver Lake Counselling Services. ❑ ______ (Initials)

Contact Person: ____________________ Phone Number: __________________________

Is the intention of attending treatment to have children returned to Applicant at the end of the Family Program?	❑ Yes ❑ No ❑ N/A

Please list any significant information with respect to your children. (Example: long-term illness, childhood, trauma, if a child has died.)

Family Supports: (Who or what supports your family's well-being?)

Family Strengths: (What does your family do or have that promotes a healthy lifestyle?)

Are there any physical challenges that require special attention in your family? ❑ Yes ❑ No

If "Yes", please explain.

Will you require assistance with reading or writing English? ❑ Yes ❑ No

Will you require an interpreter? ❑ Yes ❑ No

List any known allergies in yourself and your family:

Check any known medical conditions in your family and list any prescribed medication and its dosage:

	Name(s)	*Prescribed Medication and Dosage*
❑ Asthma	______	______
❑ Diabetes	______	______
❑ Epilepsy	______	______
❑ Seizures	______	______
❑ DT's	______	______
❑ Pregnant	______	______
❑ ______	______	______
❑ ______	______	______

Have you or anyone in your family ever contracted any communicable diseases? ❑ Yes ❑ No

E.g., TB, HIV/AIDS, Hepatitis C., bed bugs, lice, etc.

If "Yes", when?

How was it dealt with?

Is it an issue now? ❑ Yes ❑ No

All communicable diseases must be in remission and properly medicated.

Check any known mental health conditions in your family:

	Name(s)	*Prescribed Medication and Dosage*
❑ ADD	______________	______________
❑ ADHD	______________	______________
❑ Depression	______________	______________
❑ Anxiety	______________	______________
❑ PTSD	______________	______________
❑ FASD	______________	______________
❑ ________	______________	______________
❑ ________	______________	______________

PREFERRED FAMILY PROGRAM DATE

See Family Counselling Program at beaverlakecamp.org for program dates
First choice:
Second choice:

FOR THE REFERRER TO COMPLETE

Referral Worker Name:	Title:
Agency:	
Phone Number:	Fax Number:
Address:	
______________ Referral Signature	______________ Date

FUNDING

Funding Agency Name: (Please advise if cost is shared.) (Will be invoiced at the end of the program.)	
Contact Name:	Contact Phone Number:
I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by Beaver Lake Counselling Services. ____________________ Referral Signature	 ____________________ Date

Send completed application to BLCS:

Fax: 807.937.4439 Attention: Intake Worker

Email: counselling@nyp.ca

Phone: 807.700.4751 ext. 250

All information contained in this application will be treated in accordance with BLCS's privacy and confidentiality policy. (See: beaverlakecamp.org/privacy-policy/)

THIS APPLICATION IS VALID FOR ONE YEAR AFTER THE DATE SIGNED.