



MAWIOMI TREATMENT SERVICES INC.
85 SCHOOL STREET, GESGAPEGIAG, QC G0C 1Y1
TEL: (418) 759-3522 FAX: (418) 759-3048

Greetings!

I am respectfully submitting Mawiomi Treatment Services Inc.'s referral application forms and the treatment cycle schedule for 2022.

To better acquaint you with our Center: Mawiomi Treatment Services Inc. is a seven bed residential treatment center situated in the First Nation Mi'gmaq territory of Gesgapegiag. Our program duration is six weeks and offers its residents with individualized healing plans that is developed using the holistic approach. Mawiomi Treatment Services encourages and utilizes First Nation traditional values, beliefs and morals. In addition, we provide individual counseling, group circles, videos, discussions and teachings. We also host A.A. & N.A. meetings.

Mawiomi Treatment Services is honored to announce that since 2020 we have been supporting our graduates in their transition back into their communities. We have added an Aftercare Counselor and they will work with Referrals in developing a post-treatment plan. The Aftercare counselor will follow the Graduates for up to 18 months post-treatment.

Mawiomi Treatment Services Inc. is very proud to have employees that are dedicated and committed in the healing of our people. Should you require additional information please contact our Programs & Services Advisor.

In Unity and Strength,

Gloria Syvret
Executive Director



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Intake Schedule 2022

Intake Day
 Graduation
 End of Cycle
 Staff Self Care & Housekeeping
 Vacation

January						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	Admin/Training Week					8
9		11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	Cycle 1 - Jan.10 to Feb.16				

February						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15				19
20	Admin/Training Week					26
27						
Cycle 2 - Feb.28 to Apr.6						

March						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5				9
10	Admin/Training Week					16
17		19	20	21	22	23
24	25	26	27	28	29	30
Cycle 3 - Apr. 18 to May.						

May						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24				28
29	Admin					

June						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		Training Week				
5		7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		
Cycle 4 - Jun.6 to Jul.13						

July						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12				16
17						23
24						30
31	Vacation Jul.18 to Aug.5					

August						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						6
7	Admin/Training Week					13
14		16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			
Cycle 5 - Aug.15 to Sep.14						

September						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20				24
25	Admin/Training Week					

October						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2		4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	Cycle 6 - Oct.3 to Nov.9				

November						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8				12
13	Admin/Training Week					19
20		22	23	24	25	26
27	28	29	30			
Relapse Cycle 7 - Nov.21 to Dec.14						

December						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13				17
18	Admin/Training Week					24
25						



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To: All Referrals

From: Gloria Syvret
Executive Director

Subject: Intake Applications

All applications must be completed and received fourteen (14) days prior to Intake Day of the upcoming cycle. All applications received after this date will be placed on the waiting list. These changes are mandatory due to the high demand for service.

When we receive an application it will be reviewed by the Programs & Services Advisor for any missing or questionable information. If the application is complete then the potential client will be contacted for a phone interview. The phone interview will take less than 30 minutes. This part of the intake process is mandatory therefore they must provide a valid phone number on the application or make themselves available with the referral to conduct the interview.

Once that information is documented, the Clinical Team will then decide based on priority needs and readiness to change who will receive an acceptance letter.

On behalf of everyone at Mawiomí, we would like to take this time to thank you for your continued support.

Note: Please forward all applications to:

Jim Skinner
Program & Services Advisor
Mawiomí Treatment Services Inc.
85 School Street, Gesgapegiag, QC G0C 1Y1
Tel: (418) 759-3522 ext. 208
Fax: (418) 759-3048
Email: jim@mawiomí.org

DO NOT FAX APPLICATION UNTIL IT IS COMPLETE



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Client Preparation

Referral sources are requested to prepare clients for Mawiyomi Treatment Services. In particular, make sure the client is aware of the following requirements:

- a) All clients must be drug-free and/or alcohol free (7 days) in order to deter any incapacitating withdrawal symptoms; Detox may be required if less than 7 days prior to admission.
- b) Clients must be willing to abstain from all mood altering substances for the duration of the program.
- c) Clients must be able and willing to look after and be responsible for themselves. No medication (unless prescribed by a doctor for medical use) or custodial supervision is provided at Mawiyomi Treatment Center. Clients must bring sufficient money to purchase personal items such as toiletries, cigarettes, etc., and should bring a minimum of three changes of clothes.

Medication: All medications require a prescription (including any over the counter medications such as Tylenol, Cough syrup, etc). The client must arrive with the prescription and/or prescribed medications in bubble packs. Any medications in containers without prescriptions will not be dispensed.

***Client are asked to bring medications in blister packs and enough to cover the cycle when possible.**



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INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

ADULT INTAKE APPLICATION

A. General Information				
Surname:	First Name:	Nickname:	S.I.N #:	
Date of Birth: (DD/MM/YYYY)	Age:	Sex:	Provincial Health Card Number:	Expiry:(YYYY)
Address:		Home Telephone:	Cellphone:	
Education: <input type="checkbox"/> Some high school <input type="checkbox"/> Completed high school <input type="checkbox"/> Post-secondary (Cegep, Univ., D.E.P. etc.)			Employment Status:	
Treaty Number:		Band Name:		
Emergency Contact Name:		Telephone:	Relationship:	

B. Family/Relationships		
Marital Status:	How long?	
Does Client have dependent children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, do they have access to adequate childcare while in treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Are any children under youth protection or social services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Voluntary Measures <input type="checkbox"/> Court Ordered	
Does the client have other dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Provide information on client's children or other dependents:		
NAME	AGE	RELATIONSHIP
What is your family's support towards you seeking treatment?		



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C. Legal Status	
Has client been court ordered to attend treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details (include copy of probation order if applicable or available):	
Is client under any of the following legal conditions?	<input type="checkbox"/> Bail <input type="checkbox"/> Parole <input type="checkbox"/> Temp Absence Order
Does the client have any charges pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What were the charges?	Sentenced imposed?
If yes, please explain:	Court date:

D. Treatment History				
Has client participated in a non-residential/community-based substance abuse and/or mental health program?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type of program?				
Has client participated in a residential treatment program before?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide information on previous treatment experience:				
Year	Treatment Centre	Type of Addiction	Completed	Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the client been able to be sober in the past?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how long?			What did they do to remain sober?	
When was the last time they used before filling out this application?				



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What substances did they use?		
Substance	Date when last consumed	Amount consumed

E. Withdrawal Symptoms		
Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?		
Symptoms		Describe
Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Shakes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Delirium Tremens (DT)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ever experienced DT's?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

F. Process/Behavioural Addictions		
Has client experienced problems with any of the following?		
Process/Behavioural Addiction		Describe
Gambling (slots, cards, keno, bingo, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating (obesity, anorexia, bulimia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex (cheating, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Internet/Cellphone	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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G. Other Issues/Needs	
Does client have any cultural/spiritual beliefs and practices we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does client have any literacy or learning difficulty we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any other significant issues we need to be aware of? If yes, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client understand there is an expectation that they will be alcohol and drug free for at least 72 hours prior to admission to residential treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal strengths of the client?	

H. Information to be completed by the referral			
Name:	Occupation:	Agency:	
Address:			
Telephone:	Extension:	Fax:	
Has the client completed four pre-treatment appointments?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate dates below:	
Date 1:	Date 2:	Date 3:	Date 4:
Will you continue to see the client once they have completed treatment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
In your assessment, which best describes the client's level of dependency?			
<input type="checkbox"/> Chronic	<input type="checkbox"/> Acute	<input type="checkbox"/> Moderate	<input type="checkbox"/> Experimenting
Does the client recognize that they have an alcohol and/or drug dependency?			<input type="checkbox"/> Yes <input type="checkbox"/> No
In your assessment what stage of readiness to change would you place your client?			
<input type="checkbox"/> Pre-contemplation	<input type="checkbox"/> Contemplation	<input type="checkbox"/> Determination	<input type="checkbox"/> Action <input type="checkbox"/> Maintenance

 Referral Agent Signature

 Date



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Consent for Treatment & Release of Information

I, _____ have agreed to enter the Mawiomí Treatment Centre, in the First Nation community of Gesgapegiag, QC to treat my Alcohol /Drug dependency problem.

I understand that in order for clients and staff to work effectively, the treatment program will include the following:

- a. Counselling assessments – Educational sessions, one on one sessions, and aftercare planning (which includes participation in support groups).
- b. Having contact with referral resources
- c. Maintenance of confidential client records. Including the AMIS System, which include transferring of my AMIS Files between Centres.
- d. The reporting of mandatory reports, this will include the DUSI-R and the NWA.
- e. On-site surveillance Equipment.
- f. And will include random room searches when staff are directed by the Programs & Services Advisor and/or Executive Director.

I understand that if I need medical attention, the staff will make sure that proper personnel will attend to me, (and/or) I will be transferred to an appropriate facility. It may also include needing to return home if medical issues take precedence over treatment.

I understand that Mawiomí has rules, treatment expectations, whereby all residents have to abide by.

I understand the explanation of the above and therefore, consent to undergo treatment.

Date: _____ Signature: _____

Date: _____ Witness: _____

Referral Agency & Contact Person _____

Telephone # _____



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Mawiomí Treatment Center Travel Policies

- Confirmation of travel arrangements to and from the treatment center to the client's home community of residence on or off reserve must be forwarded to the Treatment Center prior to arrival.
- Clients should arrive at the Treatment Center with prepaid travel arrangements, such as airline tickets, bus tickets or an outline of ground transportation.
- All prepaid travel of clients will be provided to Treatment Center staff upon arrival and will only be returned to the client at the completion of treatment. **Clients that do not complete treatment will not be reissued their prepaid travel arrangements if the Center does not approve the early departure.**
- The Treatment Center or referring community is not responsible for clients that do not complete their treatment program due to the client being terminated by the staff or if the client decides to leave on their own for unjustified reasons.

I, the undersigned have read and understand the travel policies and therefore am aware that Mawiomí Treatment Services and my sending community are not responsible should I be terminated before graduation or should I decide to leave treatment before graduation.

Date: _____

Client Signature: _____

Referral Agent: _____



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I. Medical Assessment			
Client's Name:		D.O.B. (m/d/y):	
Health Card Number:		Blood Pressure:	Pulse:
Vision:		Hearing:	
Height:		Weight:	
Cardiovascular:	Chest:	Allergies:	Abdomen:
Present Health Problems:			
Past Health Problems:			
Is the person able to participate in physical recreation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, please explain:			
<p>In order to be considered for our program the person needs to have received at minimum one dose of the vaccination and be willing to receive the second during the program.</p> <p>Have they received the Covid-19 vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide the date of the first dose vaccinated: _____</p> <p>Please provide the date of the second dose vaccinated: _____</p> <p>Please provide the date of the booster dose if received: _____</p>			
Current Medications	Dosage	Since when?	

