MAWIOMI TREATMENT SERVICES INC.

85 SCHOOL STREET, GESGAPEGIAG, QC G0C 1Y1
TEL: (418) 759-3522 FAX: (418) 759-3048

Intake Schedule 2023

Intake Day | Graduation | Staff Self Care | Vacation

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1						7
8	Quality Improvement					14
15		17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Cycle 1 - Jan.16 to Feb.24

February

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			25
26	Quality					

March

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			Improvement			4
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	31	

Cycle 2 - Mar.6 to Apr. 14

April

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12			15
16		18	19	20	21	22
23	24	25	26	27	28	29
30	Cycle 3 Relapse - Apr.24 to May 11					

May

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

Closed For Renovations

June

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	

Closed for Renovations

July

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16						22
23						29
30		Vacation - Jul. 17 to Aug. 4				

August

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						5
6	Quality Improvement					12
13		15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Cycle 4 - Aug.14 to Sep.22

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			23
24	Quality Improvement					30

Cycle 5 - Oct.2 to Nov.10

October

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1		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				

November

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8			11
12	Quality Improvement					18
19		21	22	23	24	25
26	27	28	29	30		

Cycle 6 - Nov.20 to Dec.19

December

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		20	21		23
24						30
31	Christmas holidays Dec.22 to Jan.1					

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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 Wellness Services Manager 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 Mawiomi, we would like to take this time to thank you for your continued support.

Note: Please forward all applications to:

Jim Skinner
Wellness Services Manager
Mawiomi Treatment Services Inc.
85 School Street, Gesgapegiag, QC G0C 1Y1
Tel: (418) 759-3522 ext. 210
Fax: (418) 759-3048
Email: jim@mawiomi.org

DO NOT FAX APPLICATION UNTIL IT IS COMPLETE

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INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

ADULT INTAKE APPLICATION

A. General Information

Surname:	First Name:		Email Address:	
Date of Birth: (DD/MM/YYYY)	Age:	Sex:	Provincial Heath Card Number:	Expiry:(YYYY)
Address:		Home Telephone:	Cellphone:	
Education: ☐ Some high school ☐ Completed high school ☐ 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?	☐ Yes ☐ No
If yes, do they have access to adequate childcare while in treatment?	☐ Yes ☐ No ☐ N/A
Are any children under youth protection or social services?	☐ Yes ☐ No ☐ N/A ☐ Voluntary Measures ☐ Court Ordered
Does the client have other dependents?	☐ Yes ☐ 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?	☐ Yes ☐ No
If yes, provide details (include copy of probation order if applicable or available):	
Is client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temp Absence Order
Does the client have any charges pending?	☐ Yes ☐ 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?	☐ Yes ☐ No
If yes, what type of program?	
Has client participated in a residential treatment program before?	☐ Yes ☐ No
If yes, please provide information on previous treatment experience:	

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Has the client been able to be sober in the past?	☐ Yes ☐ 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	☐ Yes ☐ No	
Hallucinations	☐ Yes ☐ No	
Nausea/Vomiting	☐ Yes ☐ No	
Seizures	☐ Yes ☐ No	
Shakes	☐ Yes ☐ No	
Delirium Tremens (DT)	☐ Yes ☐ No	
Ever experienced DT's?	☐ Yes ☐ No	

F. Process/Behavioural Addictions

Has client experienced problems with any of the following?

Process/Behavioural Addiction		Describe
Gambling (slots, cards, keno, bingo, etc.)	☐ Yes ☐ No	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No	
Sex (cheating, etc.)	☐ Yes ☐ No	
Internet/Cellphone	☐ Yes ☐ No	
Other:	☐ Yes ☐ 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:	☐ Yes ☐ No
Does client have any literacy or learning difficulty we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Are there any other significant issues we need to be aware of? If yes, please describe:	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?			☐ Yes ☐ No
In your assessment, which best describes the client's level of dependency?			
☐ Chronic	☐ Acute	☐ Moderate	☐ Experimenting
Does the client recognize that they have an alcohol and/or drug dependency?			☐ Yes ☐ No
In your assessment what stage of readiness to change would you place your client? ☐ Pre-contemplation ☐ Contemplation ☐ Determination ☐ Action ☐ Maintenance			

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Consent for Treatment & Release of Information

I, _____ have agreed to enter the Mawiomi 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 Mawiomi 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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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:

◯ Diabetes ◯ Sleep Apnea ◯ High Blood Pressure ◯ Dental Decay
◯ Epilepsy ◯ Migraines ◯ Other: _____ ◯ Other: _____

Is the person able to participate in physical recreation? ☐ Yes ☐ No
If no, please explain:

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.

Have they received the Covid-19 vaccination? ☐ Yes ☐ No

If yes, please provide the date of the first dose vaccinated: _____

Please provide the date of the second dose vaccinated: _____

Please provide the date of the booster dose if received: _____

Current Medications	Dosage	Since when?

TB TEST MANDATORY	TB Skin Test (d/m/y):	Result:

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Provide the following information about client's health status:		
Mental Illness		Describe
Been diagnosed with a mental illness?	☐ Yes ☐ No ☐ Unknown	
Currently being treated?	☐ Yes ☐ No	
Currently on mental health medication?	☐ Yes ☐ No	
Taking medication consistently?	☐ Yes ☐ No	
Any previous suicide attempts?	☐ Yes ☐ No	
If yes, when?		
Hospitalized for suicide attempts?	☐ Yes ☐ No	
If yes, when?		
Currently suicidal?	☐ Yes ☐ No	
Name of Psychiatrist/Psychologist (if applicable):		

_____ _____ _____

Physician's Name (Printed) Telephone # Date

_____

Physician's signature