MAWIOMI TREATMENT SERVICES INC.

85 SCHOOL STREET, GESGAPEGIAG, QC G0C 1Y1

TEL: (418) 759-3522 FAX: (418) 759-3048

Intake Schedule 2024

Intake Day | Graduation | Staff Selfcare | Housekeeping | Vacation

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			Q.I.			6
7	Pre-Treatment					
	Withdraw Management					20
21	22	23	24	25	26	27
28	29	30	31			

Cycle 1 - Jan.13 to Feb.28

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	23	24
25	26	27				

March

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						2
3	Pre-Treatment					
	Withdraw Management					16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	Cycle 2 - Mar.9 to Apr.24					

April

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				27
28	Pre					

May

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			Treatment			
	Withdraw Management					11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Cycle 3 - May 5 to June 19

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				22
23	Q.I. Week					29
30						

July

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	Community Outreach Week					6
7	Community Outreach Week					13
14	Q.I. Week					20
21						27
28						

Vacation July 22 to Aug 9

August

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						3
4						10
11	Pre-Treatment					
	Withdraw Management					24
25	26	27	28	29	30	31

Cycle 4 - Aug 17 to Oct 2

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	21
22	23	24	25	26	27	28
29	30					

October

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1				5
6	STAFF STRATEGIC RETREAT					12
13	Pre-Treatment					
	Withdraw Management					26
27	28	29	30	31		

Cycle 5 - Sept 19 to Dec 4

November

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

December

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3				
	Aftercare Program					14
15	Aftercare Program					21
22						28
29						

Christmas Vacation Dec 23 to Jan 2

Intake forms must be received by our office, fully completed (medical included) 30 days prior to the intake day.

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Eligibility Requirements

As part of the application process and before an application will be considered, all applications must be filled completely, applicants must provide a contact telephone number & email address in order to conduct our pre-treatment and medical assessment.

Eligibility to our program includes individuals:
18 years of age or more
Indigenous status
Individuals with physical disability
Incarceration/Legal issues
Opiate Antagonist Therapies (OAT)

Admission Procedures

Admission into treatment is based on an application, which must include the following documents:

- Application for Admission
- Review of application to ensure complete, if not contact referral for missing information
- Provide copies of Status/Beneficiary and/or a letter from their respective community stating Proof of Status, Health Cards and/or temporary coverage.
- Medical Examination
- Authorization for Release of Personal Information
- Informed Consent and Participation Agreement
- Pre-Treatment Assessment (Mandatory telephone interview
- Medical Assessment by CHUM (Mandatory)
- Final decision is then emailed

Applications coming from the legal or penal system, require the following additional information:

- Official legal summary of past/present sentences and charges pending.
- Confirmation to go on supervised outings, as per his/her/their legal conditions (medical needs)
- Available psycho-social information, including family and social background, current behavior, etc.

The referral worker must provide their contact information (Phone extension and email), send a completed Informed Consent and Participation Agreement with the other admission documents to the Intake Worker.

For the final intake decision, a file will be considered complete once all the admission procedures have been met. Due to the high demand for treatment programs and the long process of assessment, intake will be done a month or two ahead of the intake cycle.

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WHAT YOU WILL NEED FOR YOUR STAY AT MAWIOMI

We want your stay at the Mawiomi to be as comfortable as possible. To ensure you have everything you need, please read the following list carefully.

Personal items to bring

- Personal Identification
- Medicare/Health Card
- Status/Beneficiary Card
- Bank/ATM/Credit Care ($100 - $200***)
- Smokers need to bring cigarettes.

*****Clients are not allowed to borrow money from other participants**

Clothing

- Gym clothes and running shoes
- Underwear, pajamas, socks, shirts, pants, slippers and/or moccasins (5 to 7 days' worth)
- Appropriate footwear/clothing for outdoor activities.

Medication

All medication brought to the Center is to be handed in to staff and will be monitored by staff.

Some prescribed medication, such as ointments, asthma medication, etc., will be handed back to the individual.

Medications should come in a dispill/blister pack.

Any OTC medications such as Tylenol, Ibuprofen, cough syrup, etc. must have a prescription in the file

The following items are NOT allowed

Mouthwash with alcohol
Glue (any kind)
Chewing tobacco, cigars, snuff, vapes, etc.
Weapons of any kind
Hair dye
Nail polish and/or remover
Electronic Devices (iPad, tablet, gaming console, etc.)

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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:

Jenn Isaac
Outreach Counselor
Mawiomi Treatment Services Inc.
Tel: (418)-520-6547
Fax: (418) 759-3048
Email: jenn@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

First Name:	Last 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

Who would you like to include in your Circle of Care (list 3 to 4 people)?

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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?	

What substances did they use over the last 6 months?		
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	

*Has the client **ever** experienced alcohol withdrawal complications such as hallucinations, seizures or delirium tremens (DTs)? ☐ Yes ☐ No

*Does the client have any withdrawal symptoms due to other substances?

_____

_____

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,	☐ Yes ☐ No	

etc.)		
Sex (cheating, etc.)	☐ Yes ☐ No	
Internet/Cellphone	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

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:
Email 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 Wellness Services Manager and/or any staff requested
g. Allow medical assessment by Dr. Marsan and her team at CHUM and follow recommendations provided.

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	◯ Asthma/COPD	◯ Head Trauma
◯ Chronic Pain	◯ Hepatitis C	◯ Heart Disease	◯ 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: _____

Does the client take medication? ☐ Yes ☐ No

If yes, please provide a pharmacy printout of medication history with application

It is mandatory that all clients come with medications in blister packs.

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):		

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Substance use assessment:

Substance	Type	Frequency/Quantity per day	Mode of administration
☐ **Opioids** Start date: _____ Last use: _____	☐ Dilaudid (Hydromorphone) ☐ Hydromorph Contin (hydro) ☐ Morphine ☐ Fentanyl ☐ Heroin ☐ Other: _____	Frequency (#days/wk): _____ Quantity: _____ Strength (mg/points): _____	☐By mouth ☐Smoked ☐Intranasal (snorted) ☐Intravenous (IV) ☐Intramuscular ☐Other _____
☐ **Benzodiazepines** Start date: _____ Last use: _____	☐ Rivotril (Clonazepam) ☐ Ativan (Lorazepam) ☐ Xanax (Alprazolam) ☐ Valium (Diazepam) ☐ Other: _____	Frequency (#days/wk): _____ Number of pills: _____ Strength (mg): _____	☐By mouth ☐Intranasal (snorted) ☐Intravenous (IV) ☐Other _____
☐ **Alcohol** Start date: _____ Last use: _____	☐ Wine: _____ ☐ Beer: _____ ☐ Spirits: _____	# of bottles/cans, (ml): _____ % alcohol: _____ Frequency (#days/wk):	☐By mouth ☐Other _____
☐ **GHB** Start date: _____ Last use: _____	Frequency of use in 24hr:	# of ml in 1 vial: _____ Number of vials/days: _____	☐By mouth ☐Other _____

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☐ **Cocaine** Start date: _____ Last use: _____	☐ Cocaine: _____ ☐ Crack: _____	Number of grams: _____	☐By mouth ☐Inhaled ☐Intranasal (snorted) ☐Intravenous (IV) ☐Intramuscular ☐Other _____
☐ **Other stimulants** Start date: _____ Last use: _____	☐ Speed: _____ ☐ Crystal meth: _____ ☐ Other: _____	Number of pills: _____ Or Number of grams: _____	☐By mouth ☐Inhaled ☐Intranasal (snorted) ☐Intravenous (IV) ☐Intramuscular ☐Other _____
☐ **Others**	☐ Cannabis: _____ ☐ Hallucinogens: _____ ☐ Inhalants: _____ ☐ Ketamine: _____ ☐ Tobacco/e-cig: _____ ☐ Others: _____	Quantity per day: _____	☐By mouth ☐Inhaled ☐Intranasal (snorted) ☐Intravenous (IV) ☐Intramuscular ☐Other _____

Past opioid agonist therapy (OAT): Yes ☐ No ☐

If yes, which molecule:

Methadone ☐ Buprenorphine/naloxone (Suboxone™) ☐ Other ☐

Date of last OAT: _____ Daily maximum dose in the past: _____

History of overdose: Yes ☐ No ☐

Substances involved: _____

NALOXINE KIT IN POSSESSION? Yes ☐ No ☐

_____ _____ _____

Physician's Name (Printed) Telephone # Date

_____

Physician's signature