WOLFE

Family Wellness

Working Open-heartedly, Leading Families to Empowerment

Participant Guidelines to WOLFE Family Wellness

1. This program is completely voluntary to attend and complete. Participants can leave the program at any time to be discharged with no reimbursement.
2. Must be willing to participate in all cultural activities and ceremonies
3. It is mandatory that all adult participants go to detox prior to coming to the healing Lodge and abstain from any substance use for 1 week prior to coming in for treatment.
5. All travel arrangements must be prearranged; WOLFE does not provide transportation to attend nor upon completion of treatment.
6. Random drug tests will be carried out throughout the program to ensure sobriety
7. Caregivers are expected to provide the day-to-day care of their children while attending WOLFE with staff providing support as necessary.

Referral Agent:

Referral's Name: ___________________________________

Referral Organization: ___________________________________

Job Title: ____

Telephone Number: ____

Fax: ____

Email Address: ____

Referral Signature: ___________________________________

Date: ___________________________________

If participants are non-status, please indicate the person(s)/agency that will be covering costs:

____

Reason for referral: Intended goals to be completed upon graduation of the program

____

____

____

____

____

Family Strengths: Please identify family strengths (ex. willingness to change, open communication, spirituality, accessing resources, etc.):

____

____

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____

Family Goals: Please any intended goals the family would like to achieve as a family unit.

____

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Upon completion of WOLFE: What will the referring worker involvement be with the participant/s?

____

Children Services: Is there any current involvement with Children Services, if so please state the type of order/legal status

____

Please be sure to go through the Referral Package with applicants so that they fully understand the program and its requirements.

INTAKE – Participating Family Information

Adult 1: Male □ Female □ Non-Binary □
First Name: ___________________________ Last Name: __________________
Date of Birth: ____
Street Address:____
Town/City: ___________________ Province: __________ Postal Code:________
Status: □ Yes □ No Treaty Number (10 digit): ___________________________
Alberta Health Care Number: _______________________________
Telephone Number: ____
First Nation: ____

Adult 2: Male □ Female □ Non-Binary □
First Name: ___________________________ Last Name: __________________
Date of Birth: ____

Street Address:____
Town/City: ___________________ Province: __________ Postal Code:________
Status: □ Yes □ No Treaty Number (10 digit): ___________________________
Alberta Health Care Number: _______________________________
Telephone Number: _______________________________________
First Nation: ____

Child 1: Male □ Female □ Non-Binary □
First Name: ___________________________ Last Name: __________________
Date of Birth: ____
Street Address:____
Town/City: ___________________ Province: __________ Postal Code:________
Status: □ Yes □ No Treaty Number (10 digit): ___________________________
Alberta Health Care Number: _______________________________
Telephone Number: _______________________________________
Legal Guardian: ____
First Nation: ____

Child 2: Male □ Female □ Non-Binary □
First Name: ___________________________ Last Name: __________________
Date of Birth: ____
Street Address:____
Town/City: ___________________ Province: __________ Postal Code:________
Status: □ Yes □ No Treaty Number (10 digit): ___________________________
Alberta Health Care Number: _______________________________
Telephone Number: _______________________________________
Legal Guardian: ____
First Nation: ____

Child 3: Male □ Female □ Non-Binary □
First Name: ___________________________ Last Name: __________________
Date of Birth: ____
Street Address:____
Town/City: ___________________ Province: __________ Postal Code:________
Status: □ Yes □ No Treaty Number (10 digit): ___________________________
Alberta Health Care Number: _______________________________
Telephone Number: _______________________________________
Legal Guardian: ____

First Nation: ____

Child 4: Male □ Female □ Non-Binary □
First Name: _________________________ Last Name: _________________
Date of Birth: ____
Street Address:____
Town/City: __________________ Province: _________ Postal Code:_______
Status: □ Yes □ No Treaty Number (10 digit): _________________________
Alberta Health Care Number: _____________________________
Telephone Number: _____________________________________
Legal Guardian: ____
First Nation: ____

Child 5: Male □ Female □ Non-Binary □
First Name: _________________________ Last Name: _________________
Date of Birth: ____
Street Address:____
Town/City: __________________ Province: _________ Postal Code:_______
Status: □ Yes □ No Treaty Number (10 digit): _________________________
Alberta Health Care Number: _____________________________
Telephone Number: _____________________________________
Legal Guardian: ____
First Nation: ____

Child 6: Male □ Female □ Non-Binary □
First Name: _________________________ Last Name: _________________
Date of Birth: ____
Street Address:____
Town/City: __________________ Province: _________ Postal Code:_______
Status: □ Yes □ No Treaty Number (10 digit): _________________________
Alberta Health Care Number: _____________________________
Telephone Number: _____________________________________
Legal Guardian: ____
First Nation: ____

Do applicants live on reserve? □ Yes □ No

Do the applicants and/or children currently practice any cultural traditions ? □ Yes □ No

If yes, please provide examples.

___

Do the applicants have any specific cultural teachings they would be interested in participating in ?□ Yes □ No
If Yes, please provide examples

___

MARITAL INFORMATION IF APPLICABLE

1. How long has the participants been involved in the present marital relationship?

___

2. Indicate the strengths holding the relationship together and the weaknesses that are causing problems.
Marital Strengths?

___

Marital Weaknesses?

___

3. Relationship Breakdown? i.e. Drugs, alcohol, domestic violence, etc.

___

___

4. What event(s) took place that caused the participant to seek help at this time? Include details surrounding the event(s).

___

___

___

PARTICIPANT'S PERSPECTIVE/PERCEPTION OF THE PROBLEM – This section is to be completed by the applicant/s

1. Does the participant feel they have a co-dependency problem? □ Yes □ No
If yes, explain

___

___

2. Does the participant express a need to change their life situation? □ Yes □ No

If yes, explain

3. Are Indigenous cultures and values significant for participants' change? □ Yes □ No
4. Was the participant raised by biological parents? □ Yes □ No
5. Were there alcohol or drug problems in the family of origin while the participant was growing up (ie. Parents, guardian, sibling)? □ Yes □ No If yes, explain

6. Major areas affected by substance use (such as leisure time, friends, and relationships with children). Give details

7. Has the participant previously attended substance abuse programs? Yes □ No If yes, provide details, name of the program; date attended; length of intervention; was program completed

8. What has brought you to the decision to apply for programming at WOLFE at this time:

9. Currently, what substance are you seeking treatment for?

10. How long have you struggled with substances?

11. What was the longest period of abstinence and what led to relapse?

12. Identify goals you would like to achieve upon completing programming at WOLFE?

13. Please identify all supports: family, friends, professionals, and organizations

Name	Relationship	Telephone Number

Child awareness and behaviours for each child:

Child 1 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to animals			
Fire Setting			
Bed Wetting			
Inappropriate sexual behaviours			
Suicidal ideation/Suicidal attempts			

Self-mutilation			
School absences/attendance record			
Mental health or medical diagnosis			
Daily medication			
Allergies			
Additional information to be shared			

Child 2 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to animals			
Fire Setting			
Bed Wetting			
Inappropriate sexual behaviours			
Suicidal ideation/Suicidal attempts			
Self-mutilation			
School absences/attendance record			
Mental health or medical diagnosis			
Daily medication			

Allergies			
Additional information to be shared			

Child 3 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to animals			
Fire Setting			
Bed Wetting			
Inappropriate sexual behaviours			
Suicidal ideation/Suicidal attempts			
Self-mutilation			
School absences/attendance record			
Mental health or medical diagnosis			
Daily medication			
Allergies			
Additional information to be shared			

Child 4 Name:

Behaviour	YES	NO	Describe

Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to animals			
Fire Setting			
Bed Wetting			
Inappropriate sexual behaviours			
Suicidal ideation/Suicidal attempts			
Self-mutilation			
School absences/attendance record			
Mental health or medical diagnosis			
Daily medication			
Allergies			
Additional information to be shared			

Child 5 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to animals			
Fire Setting			

Bed Wetting			
Inappropriate sexual behaviours			
Suicidal ideation/Suicidal attempts			
Self-mutilation			
School absences/attendance record			
Mental health or medical diagnosis			
Daily medication			
Allergies			
Additional information to be shared			

Child 6 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to animals			
Fire Setting			
Bed Wetting			
Inappropriate sexual behaviours			
Suicidal ideation/Suicidal attempts			
Self-mutilation			

School absences/attendance record			
Mental health or medical diagnosis			
Daily medication			
Allergies			
Additional information to be shared			

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Medical Assessment

The medical assessment has to be completed by Doctor/Registered Nurse for each family member.

To the Registered Nurse/Doctor

The aforementioned individual will undergo a medical evaluation as a potential participant in our 90-day residential program for substance use or abuse. Our program is made to help those who admit that their usage or misuse has hampered their ability to work effectively and who are physically and mentally prepared to take part in a rigorous program at WOLFE Family Wellness. The participant listed below should be free of any health issues that would limit their ability to take part in the program.

Participant Personal Information:

Date of Assessment: ____

First Name: ___________________Last Name: _____________________

Birthday (MM/DD/YYYY): _______________ Age: _______ Gender: Male Female

Alberta Health Care Number: __________________

Treaty Number: ____

Please indicate any medical illnesses or diagnoses:

____

____

____

____

____

____

Are there any current or recent medical problems which may or may not require follow-up while the participant is in treatment? Yes: ____ No: ____ If yes, please explain:

Please list all current medications for the participant: Name of Medication/ Indication/Duration:

Name of Doctor/RN: ____________________

Address: _________________________________

City: _____________________________________

Province: ___________ Postal Code: __________

Telephone: ________________________________

Fax: _____________________________________

OFFICE STAMP