

**RESIDENTIAL ADDICTION TREATMENT SERVICES APPLICATION PACKAGE – PART 1 (To be Completed and Approved Prior to Admission)**

**NOTE TO APPLICANTS:** Please complete **ALL** aspects of the *Oasis Residential Addiction Treatment Program Application Package*. ***Incomplete applications will not be processed.*** OASIS is composed of a four-phase treatment program. Each accepted applicant must enter through the REFLECTION (30-40 day entry-phase of program) and can only proceed through the subsequent READJUSTMENT (about 4 months), RECOVERY (about 12-18 months) AND REINTEGRATION (post-treatment) phases in order.

**PLEASE PRINT CAREFULLY**

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| **Application Date** | Month: Day: Year: |

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| --- | --- | --- |
| Last Name | First Name | Middle Name(s) |

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| DOB: MMM \_\_\_\_\_ DD \_\_\_\_YY \_\_\_\_  | Birthplace | Hair color | Eye color |

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| Contact Information: (phone, fax, email) |

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| Gender:  Female  Transgendered Male to Female  Male  Transgendered Female to Male |
| Ethnicity:  First Nations (Band: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Metis  Caucasian  East Indian  Asian  Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| SIN #: | PHN # |
| Emergency Contact Name: Location: Phone Number:  |

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| **Living situation last night (night before program entry):** Emergency Shelter including hotel or motel paid for by social services  Hotel or motel (where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Transitional housing  Psychiatric Unit at Hospital  Hospital (non-psychiatric)  Detox (where? )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Substance/recovery treatment facility (where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Jail, prison, correctional facility (where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Rental housing  Staying or living in a family member’s room, apartment or house  Staying or living in a friend’s room, apartment or house  Own home/parents’ home Place not meant for habitation (a vehicle, abandoned building, bus/train/airport, tent city or anywhere outside)**Length of stay at “living situation last night”:** One week or less  More than one week but less than a month  One to three months  More than three months but less than a year  One year or longer**Extent of Homelessness if applicable:** First time  1-2 times in the past  3 times in the past three years  Chronic: 4 or more times in the past three years**Reasons for current situation:** Domestic Violence  Health/Safety  Mental Health  Learning Disability  Eviction  No Affordable Housing  Substance Misuse  Addiction resulting in loss of job or family Substandard Housing  Release from Corrections Facility  Criminal Activity  Medical Condition  Underemployment/Low Income Bedbugs/other infestations (if so, which and how long ago?)  |

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| **Domestic Violence Information:**Are you a domestic Violence Victim?  Yes  NoIf yes, extent of domestic violence: within the past three months  three to six months ago  six to twelve months ago  more than a year ago |

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| **Sources of Income:** No Financial Resources  Income Assistance - welfare (Basic)  Income Assistance - welfare (Disability)  Employment Insurance (EI)  Canada Pension Plan (CPP)  Private Disability Insurance  Worker’s Compensation (WCB)  Spousal/Family Support  Employment (where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and how much do you earn? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)TOTAL MONTHLY INCOME: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RAN Mission’s Residential Addiction Treatment Services are funded through the BC Ministry of Health and BC Housing for those on Income Assistance. Clients on Income Assistance are fully paid for and the Ministry will issue you a Comforts Allowance of $95 (+/-) per month. |

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| **Education:** No Schooling completed  9th Grade  High School Diploma Elementary to 4th Grade  10th Grade  GED 5th or 6th Grade  11th Grade  Post-Secondary School 7th or 8th Grade  12th Grade, (No Diploma)Are you in school or working on a certificate or degree?  No  Yes If Yes, explain: |

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| **Legal Status**Are you a Registered Sex Offender? YES  NO Have ever been charged or convicted of sexual offenses? YES  NO Do you have any current legal charges against you? YES  NO  If YES, charged with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you currently on Probation? Are you on Probation? YES  NO  If YES, probation for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Probation/Parole Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you aware of any outstanding warrants for your arrest? YES  NO If you answered YES to the above, what is the nature of the charges? |
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| **General Health Assessment**I would rate my overall health as  Excellent  Very Good  Good  Fair  PoorAre you pregnant?  Yes Due date: MMM \_\_\_\_\_\_ DD \_\_\_\_\_ YY \_\_\_\_\_\_  No **Chemical Misuse:**Drugs: What drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drugs: What drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drugs: What drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alcohol Misuse:** How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Process Addictions:** Gambling  Pornography  Internet gaming  Cutting  Sex  Eating  Exercise  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Detox:** When/where/how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**HEALTH CONCERNS**

*To assist us in processing your application for admittance into our program, we ask that you complete the following sections as accurately as possible. Indicated health concerns will not necessarily preclude you from admittance into the program. We want to assure that should you come into the program, we have the best supports in place to assist you.*

**Section 1: Medical Health:**

Please indicate any medical issues you are currently dealing with. Check all that apply, and write down any related medications or treatment you are taking.

Allergies …………………………………. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis …………………………………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes ………………………………….. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain (location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 (location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 (location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_) medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep issues …………………………….. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brain injury ……………………………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart condition .......................... medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke ……………………………………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dietary restrictions …………………. please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crone's / Colitis ………………………. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobility problems ………………….. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infectious disease – Hepatitis B/C, HIV/AIDS, etc. (which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Methadone (\_\_\_\_\_\_\_\_\_\_ mg)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Mental Health:**

Please indicate any mental health issues you are currently dealing with. Check all that apply, and write down any related medications you are taking:

Depression …………………………….. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety…..………………………………. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bi-polar….………………………………. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PTSD…….………………………………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADHD …………………………….......... medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia ………………………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hallucinations ……………………….. medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicidal thoughts …………………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating disorder ……………………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personality Disorder ……………… medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3: Health Care Providers:**

Please provide contact information for your current and recent medical and/or mental health care providers:

 Name Phone Number Date of Last Visit

Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychologist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counsellor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Disclosure of Medical, Mental Health and Legal Information:**

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to the collection and disclosure of my personal information, including information about my medical, mental health and legal information for the purposes of determining my suitability for RAN Mission’s residential and recovery program(s) and for planning and managing my stay.*

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| --- | --- | --- | --- |
| **Individual or Agency who can be contacted** | **Who** | **Title** | **Contact Number** |
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| **Treatment History and Goals**If you have been in addiction treatment programs in the past, please complete the following”

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| --- | --- | --- | --- | --- |
| **Name of Agency** | **Dates Enrolled** | **Length of Program** | **Did you complete?** | **If not, why?** |
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**What are your goals for entering our addiction treatment program?** |

**STATEMENT REGARDING SPIRITUALITY**

RAN Mission in Chilliwack BC is a full-range service provider to support those struggling with poverty, homelessness and addiction by bringing hope and healing through the love of God. Our program and services are unapologetically spiritually-based. In this, we believe that meaningful life-change is best accomplished through a relationship with Jesus Christ. We blend biblical principles with proven life-support strategies to assist clients in pursuing their goals.

We welcome those of any faith or those of no faith to come and be part of our program but we do ask that while you are with us in the program that you be supportive of our spiritual values and the work we do which are based upon Christian principles.



*I affirm that the above information is true and complete to the best of my knowledge. I understand that if any of the above information is materially false, I may be expelled from the Residential Addiction Treatment Services at RAN Mission.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature Date

**OFFICE USE ONLY:**

**APPLICATION DECISION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONDITIONS OR ALTERNATE PLANS:**

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**ADDITIONAL NOTES:**

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**PROGRAM START DATE:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Admission Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Discharge Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Intake By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Email completed form to*** **recoverhere@ranmission.ca**

***MEN: Intake & Assessment Office 604-795-2322 extension 301 or 604-799-7114 (cell)***

***WOMEN: Intake & Assessment Office 604-795-2322 extension 207***