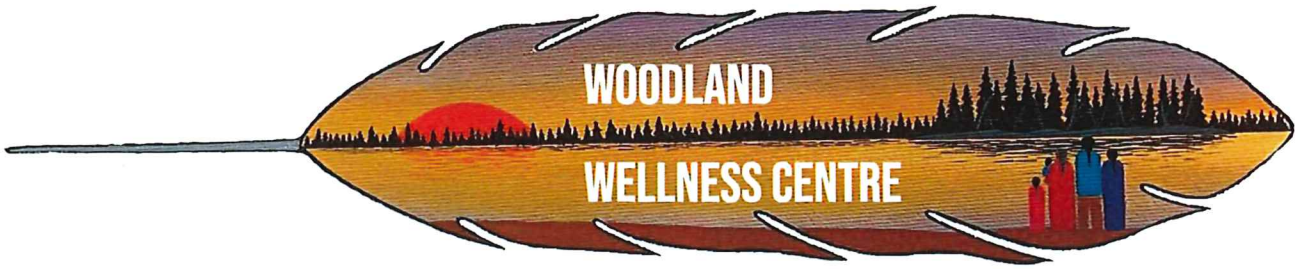


# WOODLAND WELLNESS CENTRE

# PARTICIPANT INTAKE PACKAGE

**Woodland Wellness Centre**
**Box 850, Air Ronge, SK. SOJ 3G0**
**PH: 306-425-1930 Fax: 306-425-1920**

**DATE:** _____

**PARTICIPANT NAME:** _____

# PARTICIPANT INFORMATION:

Last Name: _____ First Name(s) _____ D.O.B. _____

Nickname: _____ Self-Identified Gender: ☐Male ☐Female ☐ Other

Status Indian: ☐ Yes ☐ No First Nation/Band: _____ Live On-Reserve: ☐ Yes ☐ No

Band Number: _____ Treaty Number: _____

Health Insurance Number: _____ Social Insurance Number: _____

Address [home]: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Common-Law ☐ Widowed ☐ Divorced ☐ Separated

Family Type: ☐ Living Alone ☐ With Partner ☐ With Partner & Children ☐ With Friends

☐ Single Parent with Children ☐ With Extended Family

Number of children & ages: _____ Child & Family Services involved: ☐ Yes ☐ No

Are you mandated to treatment by court or child family services: ☐ Yes ☐ No

Do your children live with you: ☐ Yes ☐ No. If yes, how many? _____

Education Level: ☐ Grade Completed _____ ☐ High School Diploma ☐ Trade School ☐ Post-Secondary

Difficulty Reading & Writing: ☐ Yes ☐ No Learning Difficulties: ☐ Yes ☐ No

Employment: ☐ Full-Time Job ☐ Part-Time Job ☐ Unemployed ☐ Seasonal Work ☐ Home Maker

Student Residential School Attendance: ☐ Yes ☐ No. If yes, how long? _____

Did you have a family member attend residential school? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Do you require a wheelchair accessible room: ☐ Yes ☐ No If yes, please explain: _____

Do you have any physical limitations WWC needs to be aware of: ☐ Yes ☐ No

Please explain: _____

**Emergency Contact**

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cellphone: _____

PARTICIPANT DOES NOT WISH TO HAVE CONTACT WITH THIS/THESE PERSON (S): _____

SUBSTANCE USE/PROCESS ADDICTION - **HISTORY**

| SUBSTANCE OF ABUSE | METHOD OF USE: ORAL/SMOKED/SNORTED/IV | LENGTH OF USE | AMOUNT CONSUMED DAILY | DATE OF LAST USE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| TYPE OF GAMBLING OR OTHER PROCESS ADDICTION (FOOD DISORDER, INTERNET, SEX, ETC) | DURATION OF PROBLEM GAMBLING OR OTHER PROCESS ADDICTION | FREQUENCY OF GAMBLING OR OTHER PROCESS ADDICTION | LAST DATE OF GAMBLING OR OTHER PROCESS ADDICTION | SOGS (SOUTH OAKS GAMBLING SCORE) OR OTHER SCREENING TOOL |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Do you smoke cigarettes? Yes No If yes, how many cigarettes/day? _____**

**Please attach any assessments, including summaries completed in the last 7 weeks (SASSI, MAST, Etc.) which supports application to inpatient treatment admissions.**

**Check off areas negatively impacted by your use:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Housing** | | **Relationships** | | **Mental Health** | | **Other:** |
| | **Employment** | | **Physical Health** | | **School** | | **Other:** |
| | **Legal** | | **Financial** | | **Leisure time** | | **Other:** |

**Family history of substance addiction?** ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

**TREATMENT HISTORY:**

Have you previously attended Inpatient Treatment? ☐ Yes ☐ No

Year: _____ Treatment Centre_____. Type of addiction_____. Completed: ____.

Year: _____ Treatment Centre_____. Type of addiction_____. Completed: ____.

Year: _____ Treatment Centre_____. Type of addiction_____. Completed: ____.

Have you ever been discharged, or Self discharged from treatment? ☐ Yes ☐ No

If yes, please explain: _____

_____

Longest period being substance free? _____.

What helped to stay substance free previously? _____

_____.

Reason for requesting treatment currently? _____

_____

_____.

Have you ever attended: ☐ Wellbriety Meetings ☐ A.A. ☐ N.A.

☐ Support groups ☐ Other _____.

What are your strengths and motivation for Inpatient treatment? _____

_____

_____.

What will prevent you from successfully completing Inpatient treatment? _____

_____

_____.

Do you have any dependent children under your care? ☐ Yes ☐ No

If yes, share your plan for childcare while in treatment: _____

_____

_____.

What are your expectations and goals from Inpatient Treatment: _____

_____

_____.

## LEGAL:

Have you ever been convicted of a crime? ☐ Yes ☐ No

If yes, please explain: _____

_____

At the time of the offence were you under the influence of any substances? ☐ Yes ☐ No ☐ N/A

If yes, please explain: _____

_____

Do you have any charges currently pending? ☐ Yes ☐ No

If yes, what are your charges? _____

_____

Do you have an up-coming court date: _____

Current legal status: _____

Gang involvement? if so, please explain: _____

_____

_____

**Important Note for Admission**

- **Attach legal papers with treatment application. (Probation orders, CSO, Etc.).**
- **Applicant must have all legal affairs in order before being admitted into treatment. Meaning no upcoming court dates while in treatment, Inpatient Treatment requires 100 percent participation in healing sessions by the client.**
- **Woodland Wellness Centre does not accept charged or convicted sex offenders.**

**MEDICAL HISTORY:**

History of seizures, heart condition, diabetes or other? ☐ Yes ☐ No ☐ N/A

If yes, please explain: _____

Ever been hospitalized/ detoxed for excessive substance use? ☐ Yes ☐ No

If yes, please explain: _____

Participant currently Pregnant? ☐ Yes ☐ No ☐ N/A

Due Date_____

Any family psychiatric history: _____

_____

Do you have any psychiatric illnesses or symptoms? _____

_____

Any other medical issues WWC should be aware of? _____

Do you have any allergies? _____

Do you use an Epi-pen?: _____

Do you have any dietary requirements? _____

**REFERRAL AGENT:**

Name: _____ Community: _____

Title: _____ Phone: _____

Email: _____

What are your clinical/ holistic interpretations of your participant _____

_____

_____

Where is your participant on the "Stages of Change" Check one

☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance

Describe important areas that need to be addressed during your participant's treatment stay? _____

_____

_____.

Once participant has completed treatment, please provide a Treatment plan and timeline of ongoing after care_____

_____

Post-Treatment appointment date for participant with referral agent: Click or tap to enter a date.

**REFFERAL ASSESSMENT**

Has the participant ever been professionally assessed by a psychologist or psychiatrist? ☐Yes ☐No

If yes, please provide dates and details. **Attach a copy of the assessment:** _____

_____

Check all applicable boxes:

☐TRAUMA ☐DEPRESSION ☐ANXIETY/PANIC DISORDER ☐ANY TYPE OF MENTAL HEALTH DISORDER

☐ANGER/ACTING OUT ☐FAMILY TRAUMA (child apprehension, custody problems, lateral violence, marriage breakdown, etc.)

☐GRIEF AND LOSS ☐FAS/FAE ☐SUICIDE IDEATION ☐SUICIDE ATTEMPTS

Please provide brief explanation: _____

_____

_____

Is suicide a concern? ☐Yes ☐No If yes, what is the level of risk? _____

*NOTE* Please attach a copy of suicide risk assessment and safety plan, If in the last 12 months.

**PARTICIPANT SNAP (Strength, Needs, Abilities, Preferences)** (To be answered from the participant's perspective).

What does the participant believe as their:

**Strengths** (assets, resources): _____

_____

_____

_____

**Needs** (liabilities, weaknesses): _____

_____

_____

_____

**Abilities** (skills, aptitudes, capabilities, talents, competencies): _____

_____

_____

_____

**Preferences** (those things the participant thinks, feels will enhance HIS/HER treatment experience): _____

_____

_____

_____

In the participants own words, what are their presenting problems and challenges? _____

_____

_____

_____

_____

_____

**PARTICIPANT SCREENING:**

| **ALCOHOL SCREENING TEST**<br>The following questions are about your alcohol use during the PAST 12 MONTHS (Check your response). | |
|---|---|
| Do you feel that you are a normal drinker?<br>☐Yes (0) ☐NO (2) | Do friends or relatives think you are a normal drinker?<br>☐Yes (0) ☐No (2) |
| Have you attended a meeting of A.A.?<br>☐Yes (5) ☐No (0) | Have you lost friends or girlfriends/boyfriends because of your drinking?<br>☐Yes (2) ☐No (0) |
| Have you gotten into trouble at work because of your drinking?<br>☐Yes (2) ☐No (0) | have you neglected your obligations, your family, or your work for two or more days in a row because you were drinking?<br>☐Yes (2) ☐No (0) |
| have you had delirium tremens (DT's), severe shaking, heard voices or seen things that were not there after heavy drinking?<br>☐Yes (2) ☐No (0) | have you gone to anyone for help about your drinking?<br>☐Yes (5) ☐No (0) |
| have you been in the hospital because of drinking?<br>☐Yes (5) ☐No (0) | have you received a 24-hour roadside suspension, or have you been charged for impaired driving?<br>☐Yes (2) ☐No (0) |
| **Total scores may range from 0 to 29** (scores of six are greater are considered to reflect serious problems with alcohol). | **TOTAL SCORE:** |

| **DRUG SCREENING TEST**<br>The following questions are about your alcohol use during the past 12 months (please check your response). | | | |
|---|---|---|---|
| have you used drugs other than those required for medical reasons?<br>☐Yes (1) ☐No (0) | | have you abused prescription drugs?<br>☐Yes (1) ☐No (0) | |
| do you abuse more than one drug at a time?<br>☐Yes (1) ☐No (0) | | can you get through the week without using drugs?<br>☐Yes (0) ☐No (1) | |
| are you always able to stop using drugs when you want to?<br>☐Yes (0) ☐No (1) | | have you had blackouts or flashbacks as a result of drug use?<br>☐Yes (1) ☐No (0) | |
| do you ever feel bad or guilty about your drug use?<br>☐Yes (1) ☐No (0) | | Does your spouse or parents ever complain about your involvement with drugs?<br>☐Yes (1) ☐No (0) | |
| has drug abuse created problems between you and your spouse or your parents?<br>☐Yes (1) ☐No (0) | | have you lost friends because of your use of drugs?<br>☐Yes (1) ☐No (0) | |
| have you neglected your family because of your use of drugs?<br>☐Yes (1) ☐No (0) | | have you been in trouble at work because of drug abuse?<br>☐Yes (1) ☐No (0) | |
| have you lost a job because of drug use?<br>☐Yes (1) ☐No (0) | | have you gotten into fights when under the influence of drugs?<br>☐Yes (1) ☐No (0) | |
| have you engaged in illegal activities in order to obtain drugs?<br>☐Yes (1) ☐No (0) | | have you been arrested for possession of illegal drugs?<br>☐Yes (1) ☐No (0) | |
| have you ever experienced withdrawal symptoms (felt sick) when you stopped using drugs?<br>☐Yes (1) ☐No (0) | | have you had medical problems as a result of your drug use (I.E. Memory loss, hepatitis, convulsions, bleeding) ?<br>☐Yes (1) ☐No (0) | |
| have you gone to anyone for help for drug problems?<br>☐Yes (1) ☐No (0) | | have you been involved in a treatment program specifically related to drug use?<br>☐Yes (1) ☐No (0) | |
| **Score:** | 0 No Problem 1-5 Low 6-10 Moderate<br>11-15 Substantial level 16-20 Severe | **Total score:** | |

REVIEW THE FOLLOWING WITH PARTICIPANT. PARTICIPANT MUST CHECK EACH BOX AND SIGN BELOW.

☐ I understand in order to be admitted to WWC Residential Treatment, I must remain alcohol and drug free for at least three (3) full days prior to my admission/intake date and be well enough to participate in the healing sessions. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be asked to leave the WWC and will be required to reapply for treatment.

☐ I understand that the WWC is not responsible for my transportation or any other personal costs I may incur (I.E., approved medications) while I am in treatment. I will bring and give to staff all medications I am taking.

☐ I understand I cannot schedule any personal appointments (ie: Hair appt) for the period while in treatment; I must focus on my treatment healing sessions.

☐ I understand and agree to accept and attend all components of the treatment healing sessions as prescribed by the WWC, including all lectures, workshops, leisure/recreation, one to one sessions and primary group sessions.

| **Client Signature** | **Date** |
|---|---|
| | |

Woodland Wellness Centre
Box 850, Air Ronge, SK. SOJ 3G0
PH: 306-425-1930 Fax: 306-425-1920

**I, _____, hereby release**
**The Woodland Wellness Centre from any legal liability in the case of an accident/injury while attending the sweat-lodge, meat/medicine preparation, special events, any self-help meetings, use of equipment, use of fitness facility at JRMCC, or any other indoor/outdoor activities that occur off the premises of the Woodland Wellness Centre.**

**Dated in the Province of Saskatchewan, _____**

_____ _____
**Participant Signature** **Staff Signature (Witness)**

_____
**Referral Agent Signature**

# Woodland Wellness Centre

## Confidentiality Protocol

You are entitled to enter the Woodland Wellness Centre with the understanding that any information disclosed to a staff member will be held in strict confidence. This is inclusive of all records, materials, oral or written communication.

**Counsellors may choose or be obligated to break confidentiality under the following circumstances:**

1. You disclose that you are intending to harm another person.
2. You admit to a plan to harm yourself.
3. You disclose that a child less than 16 years of age is being abused or neglected.
4. You are in medical distress and unable to speak.
5. Your file is subpoenaed by the court.
6. The police have a warrant for your arrest.

Staff members of the Woodland Wellness Centre are bound by the rule of non-disclosure during and after employment at the Woodland Wellness Centre.

As well, you can not share any information about another participant or share if another participant is in treatment. A simple definition of confidentiality is: **"Who you see here, what is said here, when you leave here, let it stay here"**.

Date: _____

_____ _____

Participant Signature WWC Counsellor Signature

_____

Referral Agent Signature

**PLEASE NOTE, ALTHOUGH ALL PARTICIPANTS SIGN A CONFIDENTIALITY PROTOCOL FORM WHILE ATTENDING AT THE WOODLAND WELLNESS CENTRE, THIS DOES NOT MEAN THAT THEY WILL MAINTAIN CONFIDENTIALITY.**

# PARTICIPANT'S PROHIBITED BELONGINGS LIST

**Prohibited Items Include:**

| | | |
|---|---|---|
| Clothing that promotes alcohol or references alcohol or drugs | Perfumes, Colognes | Nail Polish, Nail Polish Remover, or Synthetic Nail Related Products |
| Clothing promoting anything inappropriately (Sex, drugs, violence) | Mouth Wash | Unapproved medications |
| Over the counter medications (Will be disposed of immediately if unsealed) | Alcohol or Drugs (Will be disposed of immediately) | Pornography |
| Weapons (Guns, knives, scissors or sharp objects, ropes, etc.) | Revealing clothing (tank tops, sleeveless shirts, short shorts or skirts) | Radios |
| Food or drinks | Products that contain alcohol | Hairspray or aerosol items |
| Electronics (Video Games, Gaming Consoles or DVDs, Cameras, etc.) | Cleaning supplies (Bleach, ammonia, etc.) | Candles and incense |
| Cellphones, Ipads, Tablets, Smartwatch | | |

**(after reviewing with participant please sign below)**

**Participant Signature:**_____ **Referral Agent Signature:** _____

**LIST OF ITEMS TO BE KEPT IN STORAGE. (ie: Cell Phones, Ipads, Tablets)**

| ITEMS | TOTAL | COMMENTS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***These items are stored in the storage cabinets in the Intake Office***

*Upon discharge/completion of treatment stay, signatures below confirm items were returned...*

**WWC Staff:** _____ **WWC Staff Witness:** _____

**WWC Counsellor:** _____

Medical Form (Must be completed by Physician or Nurse Practitioner)

Participant First Name: _____ Last Name: _____

Participants Date of Birth: _____ Health Card Number: _____

Physician Name: _____ Phone Number: _____

***Please check yes or no to indicate if client is currently being treated for or if they have a history of any of the following:***

| | YES | NO | PLEASE PROVIDE DATES AND DETAILS |
|---|---|---|---|
| **Tuberculosis** | O | O | |
| **Heart Disease** | O | O | |
| **Mental Illness** | O | O | |
| **Epilepsy** | O | O | |
| **Seizures – other than Epilepsy** | O | O | |
| **High Blood Pressure** | O | O | |
| **Cancer** | O | O | |
| **Allergy** | O | O | |
| **Stroke** | O | O | |
| **Diabetes** | O | O | |
| **Back Pain** | O | O | |
| **Venereal Disease** | O | O | |
| **Emphysema or other Lung Disease** | O | O | |
| **HIV/AIDS** | O | O | |
| **Hepatitis A B C** | O | O | |
| **Scabies** | O | O | |
| **Lice** | O | O | |
| **Pregnancy** | O | O | **LPM / / / Live Births: D M Y** |
| **Special Diet** | O | O | |

| CURRENT MEDICATIONS | DOSAGE | REASONS/COMMENTS |
|---|---|---|
| | | |
| | | |
| | | |

**IMPORTANT NOTE FOR AMDMISSION CRITERIA**

- The participant's 1 WEEK SUPPLY of medications are required to be blister packed
- Please list admission diagnosis with a brief history of present active medical conditions.
- Provisions for any follow-up treatments or care required while in WWC? Please specify.
- Any pertinent physical exam findings? Please specify.

**Medical Form Continued**

Physician/Nurse Practitioner Name: _____

Address: _____

Phone: _____ Fax: _____

_____

Physician/Nurse Practitioner Signature

_____

Date

Office Stamp

**NOTE: Please ensure you have read and reviewed the Safe/Unsafe Medication List on page 16. Non-compliance with said list will result in the applicant not being accepted into Woodland Wellness Centre.**

## Woodland Wellness Centre Fax #: 306-425-1920

## UNSAFE

**Avoid pain medications that contain Opiates (I.E. Codeine):**

- Tylenol 1, 2, 3 or 4 (all Opioids)
- Demerol
- Percocet
- Fiorinal Plan ¼ or ½
- Levo-Dromoran
- 222, 282, 292, 692, Darvon (Propoxyphene)
- Talwin
- Percodan
- Leritine
- Dilaudid
- Nabilone
- Gabapentin

**Avoid Nerve and Sleeping Pills including:**

- Librium
- Tranxene
- Serax
- Xanax
- Others used for anxiety/nervousness/ tranquilizer
- All Benzodiazepines

**Avoid CNS Stimulants such as Methamphetamines:**

- Dextroamphetamine (Dexedrine)
- Lisdexamphetamine

**Avoid Sleeping Pills including these and others:**

- Dalmane
- Halcion
- Restoril
- Tuinal
- Seconal
- Zopiclone (Imovane)

**Avoid Muscle Relaxants:**

- Robaxisal
- Robaxacet
- Parafon
- Flexeril

**Over the Counter Medications can be a Serious Threat:**

- Cough syrups contain alcohol, codeine and antihistamines. These are all drugs which need to be avoided.

**Avoid Sedating Antihistamines such as:**

- Gravol
- Actifed
- Dimetap
- Chlortriplon
- Benydryl or products containing diphenhydramine

## SAFE

**Pain Medications:**

- ASA or Aspirin
- Advil or Ibuprofen
- Midol

**Available Only by Prescription:**

- Tryptan
- Buspirone (Buspar)
- Toradol
- Possible other prescription medications – please contact Resident Nurse for clarification

**Antidepressants Safe with Proper Use and by Prescription Only:**

- Elavil
- Citalopram
- Morex
- Serzone
- Desipramine
- Effexor (Venlafaxine)
- Zoloft (Sertraline)
- Prozac (Fluoxetine)
- Luvox (Fluvoxamine)
- Paxil (Paroxetine)
- Trazodone (Desyrel)
- Mirtazapine
- Buproprion
- Seroquel (Quetiapine)

**Migraines:**

- Imitrex

**Non-Sedating Antihistamines:**

- Seldane
- Claritin
- Hismanil

**Sleep Aids:**

- Epsom Salt
- Melatonin
- Calcium (333mg) Magnesium (167mg) with VD3 (5mcg)
- Lavender Oil

**Note:** This is a partial list. If you require more information, please ask the doctor or pharmacist about non-psycho active/mood-altering medications.

Woodland wellness centre

Participant name:

Allergies:

Age:

| Date | Time | Drug name, Dose, Route, Dosing interval.<br>One week supply. | MAR | Nurse initials |
|---|---|---|---|---|
| | | Thiamine 100mg PO daily (for 7 days) | | |
| | | Folic Acid 1mg PO daily (for 7 days) | | |
| | | General medications:<br>Take medications as previously prescribed in bubble pack. | | |
| | | | | |
| | | | | |
| | | | | |
| | | Ibuprofen 200 mg 1-2 tabs every 6-8 hours by mouth when needed. | | |
| | | Tylenol 500 mg 1-2 tabs every 4-6 hours by mouth when needed. | | |
| | | Dimenhydrinate (GRAVOL) 25-50mg every 6 hours by mouth when needed. | | |
| | | DiphenhydrAMINE (Benadryl) 25-50mg every 6 hours by mouth and reassess participant within 30 minutes. If symptoms persist or progress and signs of severe allergy/anaphylaxis, transport to Emergency department and consult physician directly. | | |
| | | | | |
| | | NIX Shampoo 1%- apply once and repeat in 7 days, if lice or nits still present. | | |

Prescriber signature:

Date/time:

# PRESCRIBER'S ORDERS
# Woodland Wellness Centre

**Participant Name:**_____

| Date | Time | Drug Order Format: Generic Drug Name, Dose, Route, Dosing interval | MAR | Nurse Initials |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |


**Woodland Wellness Centre**

**Treatment Admission Policy**

1. The applicant must be eighteen years old or older to attend services.

2. Participants must be sober for a minimum of 2 weeks prior to treatment at WWC.

3. If WWC staff suspects drug/alcohol use, a drug test will be done; if WWC finds that a participant has used the participant will be discharged from treatment.

4. Participants will be on a 10-day settling in period; there will be no visits or phone calls during the first 10 days in treatment.

5. All referral agents are responsible for transportation to WWC. Transportation arrangements to and returning back to a participant's home community will be the responsibility of the community or referral agent. If the participant uses their own means of transportation; WWC will require the keys to be turned in upon arrival.

6. WWC is responsible to provide In-patient Treatment services to all Lac La Ronge Indian Band communities (Stanley Mission, Hall Lake, Grandmothers Bay, Sucker River, Little Red and La Ronge area). If full capacity is not met, WWC will accept other First Nations applicants, Non-Status, Metis and Non-First Nations from anywhere in Canada.

7. Participants must arrive on the scheduled intake date- no later.

8**. The admission policy, house guidelines, application form, medical examination form and conditions of Agreement form need to be signed and completed by the participant and the referral agent and then submitted for screening to WWC**.

9. The applications will be reviewed and approved by the WWC Team.

10. A letter of confirmation of acceptance **is necessary** in order to be accepted into WWC Treatment.

11. Participants are responsible to arrange their own legal, medical and other personal matters to be taken care of before or after WWC treatment. No exceptions.

12. Prescribed medications and over the counter drugs will be retained by WWC. Preferably blister/bubble packed.

13. WWC is required to inspect each participant's belongings upon admittance.

14. Referral agents are responsible for participants during treatment.

15. WWC has the right to discharge any participant that does not want to follow the treatment plan or rules of WWC.

16. Those who transport participants to WWC cannot leave until a drug test and Covid test is completed. If either test is positive- the participant will be required to return with their transportation driver to their home community.

I understand and agree with the admission policy.

Participant Signature: _____ Date: _____


**Woodland Wellness Centre**

**Treatment House Guidelines**

The Woodland Wellness Treatment Centre offers addictions treatment services to people with alcohol, drug and gambling problems. During your stay, we will work with you to help you address these problems and we kindly ask you to follow the WWC Addictions Treatment Plan. To help with this, please follow the House Guidelines listed:

1. At no time will participant(s) threaten or try to intimidate WWC Staff or other participants during the 4-to-6-week WWC Healing sessions. Failure to comply will result in immediate dismissal from WWC Treatment.

2. In the event that a WWC participant becomes physically aggressive or threatening towards staff or other participants, the WWC will contact RCMP to remove the participant from the premises.

3. WWC has healing sessions with planned activities- please follow the activities as scheduled.

4. During the settling in period- there will be no phone calls or visitors for 10 days.

5. Smoking, beverages and food are allowed only in designated areas.

7. Participants are not to purchase energy drinks during their stay at WWC.

8. Cell phones and electronics are not permitted.

9. TV is a privilege and will not be allowed during sessions; failure to comply with the rules will result in a verbal warning.

10. Participants will not ask staff to use office phones for any reason; no exceptions.

11. Sexual relationships are not permitted at any time between participants/staff during your stay.

12. Participants are expected to be awake by 7am each morning; except on weekends. Participants should be awake by 8am.

13. Lights are out every evening by 11pm from Sunday to Friday. Lights are out at 12pm on Saturdays.

14. TV, radio or any other music should be off by 11pm each night.

15. Participant outings are a privilege and can be taken away in the event that a WWC Wellness Worker finds it necessary to do so.

17. Participants are responsible for making their beds and cleaning their bedrooms each morning and replacing their sheets every Saturday.

18. Participants will be assigned specific housekeeping duties which will be rotated on a weekly basis; failure to comply could lead to a verbal warning and will be documented in a participant's chart.

19. Participants are expected to attend all WWC healing sessions and activities, including AA meetings, outside meetings, recreation and other group activities.

20. WWC rooms are designated for male and female; men are not allowed in woman's rooms and vice versa. Gender identity will be considered.

21. During treatment, participants are not allowed to visit homes or relatives.

22. Respect one another's customs and beliefs.

23. Dress properly and accordingly while in treatment.

24. Staff are not responsible for any items left at WWC.

25. Violence or threats against staff will not be tolerated; failure to comply could lead to automatic discharge of treatment.

26. Alcohol and drug use is prohibited. If the participant is suspected of using any substances, a drug test will be done. If the result is positive- immediate discharge will occur.

29. Rooms will be inspected by staff on a regular basis.

30**. <u>NO SWEARING</u> allowed at any time during your stay**; you will be given 2 warnings; A third warning is ground for dismissal from WWC.

31. If three verbal warnings are given (due to not following House Guidelines)- and after the third warning- a participant will be involuntarily discharged from WWC.

I understand and agree to follow these House Guidelines.

Participant Signature: _____ Date: _____

Witness: _____ Date: _____