RESIDENTIAL SCHOOL TRAUMA HEALING PROGRAM

A Treatment Program of the
Ktunaxa/Kinbasket Wellness Centre
3246 Riverview Rd
Creston, BC VOB 1G2

Ph. (250) 428 – 5516
Fax. (250) 428 – 5235
Email: kkwc@shawcable.com
Web Site: www.healingisajourney.com

Our Philosophy (Our Prayer)

The Ktunaxa/Kinbasket Wellness Centre **recognizes that the residential school system has hurt and devastated All First Nation's People. We believe that a healing process begins with self to rebuild family, community and world in a spirit of hope, love and care.**

Our Mission

The Ktunaxa/Kinbasket Wellness Centre **will provide a safe place for people to begin a healing journey from the devastation of residential school systems by promoting safe ways to break the silence and honor our voice, our story, ourselves.**

Wellness Planning and Self Care

The Residential School Trauma Healing Program has created a personal wellness model utilizing the concept of the Medicine Wheel, Physical, Emotional, Social/Cultural, and Spiritual. This wellness plan will be followed by all of the Applicants entering the program. This wellness plan must be a continuous personal day-to-day form of action that maximizes our potential in each direction of the medicine wheel.

Aboriginal/European Historical Perspectives

Explores the traditional heritage of the Aboriginal peoples before the coming of the first Europeans. Discussions will examine cultural, tradition, language, spirituality, and family ways. Focus will be on the impact of residential schools to all Aboriginal people.

Residential School Syndrome

Explores the changes that the Aboriginal people experienced resulting of the coming of the Europeans. Focus will be on the impact of residential schools to all Aboriginal people.

Dynamics of Grief and Loss

Explores loss and resultant grief. The knowledge of these issues in the Family Reconstruction setting establish continuation of healing and recovery from the trauma for residential schools.

Post Traumatic Stress Disorder

Designed to help participants recognize and assess post traumatic stress disorder symptomology and to understand its relationship to residential school survivors.

Physical & Sexual Abuse

Designed to provide participants with information, knowledge and understanding of the dynamics of physical and sexual abuse. The impact resulting from residential school, and primary areas of dysfunction, (pain), contributing to the precipitation of personal and family crisis.

Cultural Systems – Values & Beliefs

Designed to provide participants with knowledge and skills in the identification and exploration of cultural ramifications. Provide an opportunity for participants to enhance their effectiveness by addressing systemic and personal issues of living in a cultural diverse atmosphere.

Family Systems

Examines the family as a system, utilizing family systems theory approaches for healing. Assist participants in understanding the effects of residential school on the Aboriginal family system, including relationships, co-dependence, and adult children of alcoholic issues.

IMPORTANT

To: **ALL REFERRAL WORKERS & APPLICANTS**

From: **KKWC Director**

RE: **Mandatory T.B. Testing**

The Ktunaxa/Kinbasket Wellness Centre would like to take this opportunity to inform all possible applicants that Tuberculosis Tests are now required by Law in British Columbia with your application to any B.C. Treatment Centre.

Please abide by these rules and send your T.B. Test Results with your Application for Treatment or you will not be considered for admission to our facility. Also, please note that if you have received a negative T.B. Test within the last 12 months, we will accept a copy of those results with your Application.

Thanking you in advance for your attention to this matter. If you have any further questions, please feel free to contact us at:

Ktunaxa/Kinbasket Wellness Centre Society
3246 Riverview Rd - Creston, BC V0B 1G2
PH: (250) 428-5516 or FAX: (250) 428-5235

or you may choose to E-mail us at:
kkwc@shawbiz.ca
or visit our Website at:
www.healingisajourney.com

KTUNAXA/KINBASKET WELLNESS CENTRE

3246 RIVERVIEW RD
CRESTON, BC V0B 1G2
PH: (250)428-5516 • FAX: (250)428-5235
E-MAIL: kkwc@shawcable.com

REFERRAL AGENCY: ____

REFERRAL ADDRESS:

____

PHONE: ________________________ FAX: _______________________________

REFERRAL WORKER: ____

RESIDENTIAL SCHOOL TRAUMA HEALING PROGRAM

RESIDENTIAL SCHOOL CHECKLIST

θ SURVIVOR θ DESCENDANT θ COUNSELLOR

RESIDENTIAL SCHOOL ATTENDED: _______________________________________
YEARS AT RESIDENTIAL SCHOOL: _________________ TO: _________________

I. PERSONAL INFORMATION

SURNAME (legal): ____________________ GIVEN NAME: _____________________

Also Known As (if different from above): _______________________________________

ADDRESS: ____

CITY: _______________________________ POSTAL CODE: ___________________

Home PHONE: _______________________ Work PHONE: _____________________

BIRTH DATE: Year ____ Month ____ Day ____ GENDER: θ Male θ Female

ANCESTRY/NATION: ____

BAND NAME: ________________________ STATUS #: _______________________

BC MEDICAL #: ______________________ SIN #: ___________________________

How are Medical Insurance Premiums Paid? θ D.I.A. θ Social Services θ Self

EMERGENCY CONTACT: ____

Emergency ADDRESS: ____

Emergency PHONE: ___________________ RELATIONSHIP: ___________________

MARITAL STATUS: θMarried θDivorced θSeparated θWidowed θCommon-Law

FAMILY TYPE: θ Couple θ Spouse & Children θ Single Parent θ Living Alone

θ Living w/Friends θ Living w/Parents θ Living w/Extended Family

NUMBER OF CHILDREN: _____ θ At Home θ In-Care θ Apprehended: _________

Have you secured Child Care for the "RST" Healing Program? θ Yes θ No

Have you been raised by your Natural Parents? θ Yes θ No

Have you been in Foster Care? θ Yes θ No When? _______

Do you speak your traditional language? θ Yes θ No

Primary language spoken at home: ____

Native Culture & Spirituality practiced? θ Yes θ No

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APPLICATION

I. PERSONAL INFORMATION
(…Continued…)

ALLERGIES: Medications: ____

Foods: ____

Other: ____

Are you Diabetic? θ Yes θ No

Do you require a Special Diet? θ Yes θ No

If so, please indicate: ____

____

Any Eating Disorders (e.g. loss of appetite, anorexia, bulimia, over-eating)? θ Yes θ No

If yes, please identify: ____

Please identify your Sleeping Habits: ____

Have you ever attempted, thought about, or had Suicidal tendencies? θ Yes θ No

If so, please indicate when: ____

Is you Medical Doctor aware of any of the above Medical Problems? θ Yes θ No

FAMILY PHYSICIAN: ____

PHYSICIAN ADDRESS: ____

____

Physician PHONE: ____________________ Physician FAX: ____________________

EDUCATION: θ Public (on-reserve) θ Public (off-reserve) θ Residential School

Grade Completed: _____ Where? ____________________ When? ______________

Did you complete: θ Community College θ University θ Trade School θ Other

Please indicate any Training Certificate/Diploma/Degree: ____________________

Do you have problems with… Reading - θ Yes θ No Writing - θ Yes θ No

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APPLICATION

I. PERSONAL INFORMATION
(…Continued…)

EMPLOYMENT: Usual Occupation: ____

θ Self employed θ Homemaker θ Job Training θ Seasonal θ Permanent

θ Retired θ Student θ Temporary θ Unemployed θ Full-Time θ Part-time

INCOME SOURCE: θ Job θ Income Assistance θ E.I. θ Family Allowance

θ Pension θ Interest θ Family θ None θ Other: ______________________

LEGAL STATUS: θ Does Not Apply θ Probation θ Day Parole θ Bail

θ Court Order θ O.R. θ Electronic Monitoring θ Other: ____________________

Reason for Conviction (e.g. B&E, Sexual Offense, Violence, etc.):

____

Date of Release: ____________________ Length of Supervision: _________________

Alcohol/Drug Related Charges? θ Yes θ No Pending Court Date: ______________

PLEASE NOTE: All court dates, Pending Charges, etc. must be dealt with prior to Intake to the Ktunaxa/Kinbasket Wellness Centre. Any Court "Conditions" of Probation, Parole or Electronic Monitoring must accompany the Application.

If Probation and/or Parole have "conditions" to the client attending the program, the Probation/Parole Officer will be notified by KKWC if the client completes or does not complete the Program.

PAROLE/PROBATION OFFICER: ____

ADDRESS: ____

PHONE: ______________________________ **FAX:** ____________________________

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II. ADDICTION HISTORY
(…Continued…)

What Is your Motivation for coming into the "RST" Healing Program?___________

____

____

____

Date of last Alcohol and/or Drug Use: _______________________________________
(please note: Admission Criteria is a minimum of 1 year of Sobriety)

CHEMICAL USE HISTORY:

1. History of Substance Use:

SUBSTANCE	Drug Type	Daily or Weekly	Amount used	Age you started	Age of last use
ALCOHOL: (Beer, Wine, Whiskey, Vodka, etc.)					
HALLUCINOGENS: (Marijuana, Acid, PCP, etc.)					
NACOTICS: (Cocaine, Opium, Crack, Heroine, etc.)					
PRESCRIBED: (Codeine, Morphine, Valium, etc.)					
TOBACCO: (Cigarettes, Snuff, Pipe)					
INHALANTS: (Gas, Glue, Lysol, Hairspray, Paint, etc.)					

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II. ADDICTION HISTORY
(…Continued…)

2. What was your Reaction to the Abuse? ____________________________________

    ____

3. Have you used shared needles from other IV Drug users? θ Yes θ No

    If so, When was your First IV use? __________________ Last? _________________

4. Do you have process addictions? (e.g. Gambling, Shopping, Work) θ Yes θ No

    If yes, please Identify: ____

5. Are you currently on any Medications? θ Yes θ No
    a) Name of Medication: ____
    b) Amount Prescribed: ____
    c) Purpose of Medication: ____

6. Any Alcohol and/or Drug problems in your Family of Origin? θ Yes θ No

7. Has there been a death in the Family of Origin due to Alcohol/Drugs? θ Yes θ No

III. PRESENTING PROBLEMS and/or ISSUES

1. Have you suffered any of the following Abuses?
    a) Physical Abuse θ Yes θ No
    b) Emotional Abuse θ Yes θ No
    c) Sexual Abuse θ Yes θ No
    d) Mental Abuse θ Yes θ No

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III. PRESENTING PROBLEMS and/or ISSUES
(…Continued…)

TREATMENT HISTORY:

2. Prior Treatment::

TYPE OF TREATMENT	PRESENTING PROBLEM	PLACE NAME ADDRESS	START & END DATES
ALCOHOL AND DRUG			
EMOTIONAL OR FAMILY			
PROCESS ADDICTIONS			
SUICIDE/PSYCH SERVICES			

3. Have you successfully completed any of the Programs listed above? θ Yes θ No

   If not, what were the circumstances? ___________________________________

   ____

   ____

4. Have you had previous contact with the present Referring Agency? θ Yes θ No

   If yes, how often? θOnce θWeekly θBi-Weekly θMonthly θOther: _________

5. Have you had previous Psychiatric Care? θ Yes θ No

   If yes, When? _______________________ Where?: _______________________

6. REASON FOR REFERRAL TO "RST" HEALING PROGRAM:
7.

IDENTIFIED ISSUES:	IDENTIFIED GOALS:

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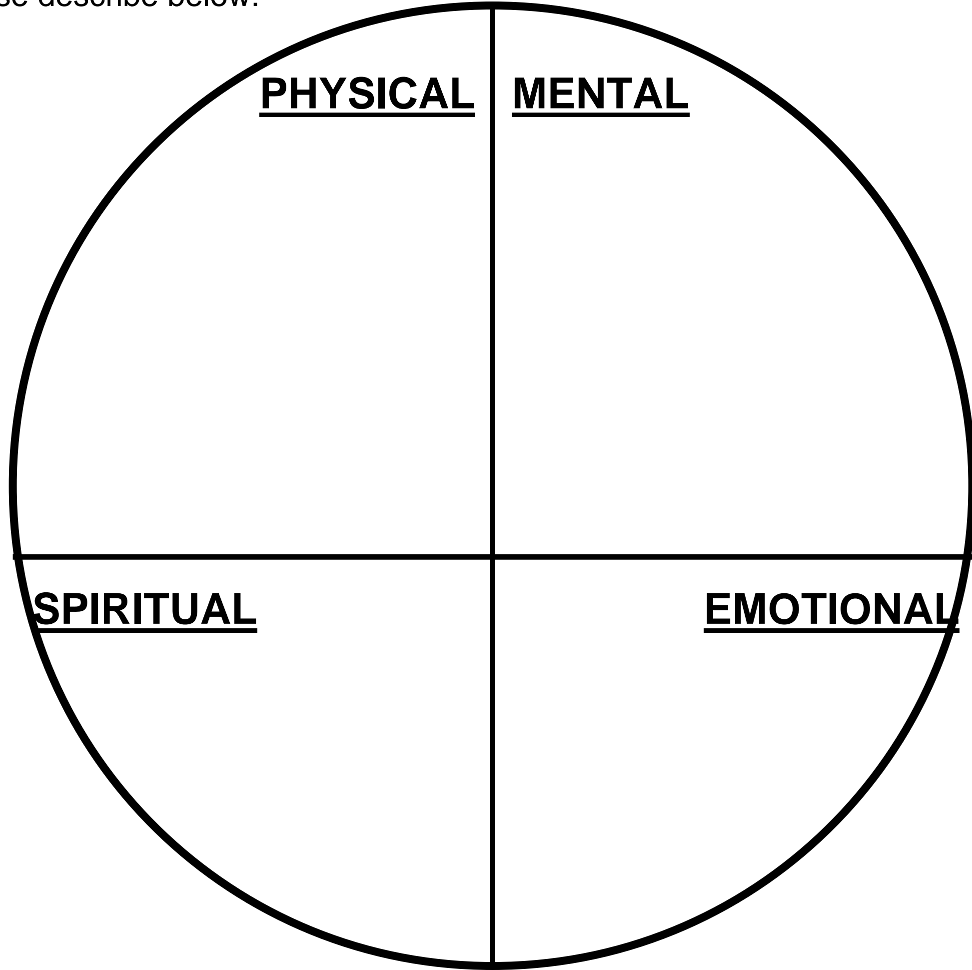
III. PRESENTING PROBLEMS and/or ISSUES
(…Continued…)

7. Do you currently have a WELLNESS PLAN in place? θ Yes θ No
   If yes, please describe below:

Your Wellness Plan should indicate what you "DO" for yourself in each area (PMES) on an on-going basis - . . .



8. Are you willing to actively follow your Aftercare Plan? θ Yes θ No
   If so, please describe what Resources you have in place to follow your aftercare plan: ____
   ____
   ____

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KKWC REFERRAL PACKAGE

IV. CONSENT FOR TREATMENT

I, ____, agree to enter the Ktunaxa/Kinbasket Wellness Centre for the purpose of treatment and healing myself.

I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.

I also agree to be involved in my Aftercare Plan and Outpatient Counselling after attending the Ktunaxa/Kinbasket Wellness Centre.

I fully understand the above points and the Ktunaxa/Kinbasket Wellness Centre Guidelines; therefore I consent to undergo Residential School Trauma Treatment at the Ktunaxa/Kinbasket Wellness Centre.

Date:____________________________Signature:____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I hereby give my consent for staff personnel of the Ktunaxa/Kinbasket Wellness Centre to use my client file for the purpose of data collection for the outcome study and program development.

I hereby give my permission for staff personnel of the Ktunaxa/Kinbasket Wellness Centre to contact:

Name: ____Title: _______________________
(example: referral worker, probation officer, parole officer, psychologist, etc.)

Address: ____ Phone: ___________________
(of Contact person named above)

for information to be released which shall be limited to

____
(example: progress during treatment, discharge summary, etc.)

Date: _____________________________Signature ____

WitnessSignature__________________________________Location___________________________
(Note: This form is applicable for one year after signed and dated)

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KKWC REFERRAL PACKAGE
V. PRE-ADMISSION MEDICAL EVALUATION

CLIENT NAME: ____D.O.B.: ________________
B.C. MEDICAL #: ______________________________________ STATUS #: ________________
ADDRESS: ____
CITY: ____________________________________PROVINCE: _______POSTAL CODE: ___________

CLIENT RELEASE

I, _____________________________ hereby request and permit Dr.___________________________

my physician, to release medical information about me to:

Ktunaxa/Kinbasket Wellness Centre
3246 Riverview Rd - Creston, BC V0B 1G2
PH: (250) 428-5516 - FAX: (250) 428-5235

and my Referral agency:

AGENCY NAME: ____
CONTACT NAME: ____
ADDRESS: ____
PHONE: ___________________________ FAX: ________________________

Client Signature: ____ Date: ______________

TO THE PHYSICIAN:

Your patient is being considered for admission to the Ktunaxa/Kinbasket Wellness Centre, an in-patient Alcohol & Drug & Trauma Treatment Facility. Please indicate whether or not this patient suffers from Psychological Disorders of any kind...and if you would recommend Treatment for this client.

For patients who suffer from chemical dependency, treatment is usually the beginning of a life long process of recovery and not an end unto itself. It is essential that an aftercare plan be in place upon return to their communities for there to be much hope of keeping the disease in remission. Family physicians are in a unique position to help co-ordinate such plans with various other resources in our communities , such as chemical dependency counsellors, and other recovery resources, eg. AA and NA groups.

Also, please NOTE: The applicant is responsible for any fees incurred by filing this Medical Examination information for Treatment.

"RST" APPLICATION

C REFERRAL PACKAGE

V. PRE-ADMISSION MEDICAL EVALUATION

(CONTINUED)

MEDICAL EXAMINATION

Would you like to receive a Discharge Summary≅ on your patient? **Γ YES Γ NO**
Would you Recommend in-patient Alcohol & Drug Treatment? **Γ YES Γ NO**

FUNCTIONAL INQUIRY AND PHYSICAL EXAM:

Diabetes: ΓYES ΓNO Allergies:____

EENT: Hearing Loss ΓYES ΓNO Impaired Vision ΓYES ΓNO

RESP: Asthma ΓYES ΓNO S.O.B. ΓYES ΓNO Chronic Cough ΓYES ΓNO

CVS: CHF ΓYES ΓNO Angina ΓYES ΓNO Prev. Endocarditis ΓYES ΓNO

GI: Ulcers ΓYES ΓNO Reflux ΓYES ΓNO Dyspepsia ΓYES ΓNO IBD ΓYES ΓNO

GU: Frequent UTI ΓYES ΓNO Prostatism ΓYES ΓNO

Menstrual: LMP:______________________Pregnant? ΓYES ΓNO EDC:___________________

PHYSICAL EXAMINATION:

BP:______ / ______

EENT: NEG POS ____

CHEST: NEG POS ____

HEART: NEG POS _______________________________Murmurs______________________

ABDM: NEG POS Hep: _____ Type: _____ Liver_____________ Scars_____________

GU: NEG POS _______________________________Last Pap______________________

NEURO: NEG POS ____
LOCOM: NEG POS ____

SKIN: NEG POS __________ Infestations__________ Infections_______________

HIV/AIDS: Testing ΓYES ΓNO Results: ____

"RST"
APPLICATION

KKWC REFERRAL PACKAGE
V. PRE-ADMISSION MEDICAL EVALUATION
(CONTINUED)

Is this patient on any prescribed medication? Γ **YES** Γ **NO**

For what purpose: ______________________________

Name of Medication: ______________________________

Amount prescribed: ______________________________

Any current or recent medical problems which mayor may not require follow-up while in treatment?
Γ **YES** Γ **NO**

If so, please explain: ______________________________
____

Is this patient able to participate in scheduled Recreational activities (eg. Aerobics, Bowling, etc.)?
Γ **YES** Γ **NO**

If not, please explain: ______________________________

<u>AS A PRE-REQUISITE TO TREATMENT YOUR PATIENT MUST:</u>

Be free from all communicable diseases (i.e. STD, Scabies, Lice, etc.) Γ **YES** Γ **NO**

Have a negative T.B. Test in the last 12 months. **POS** **NEG**

Date: ______________________ ***(Please attach documentation/results)***

Be clean and sober from Alcohol & all Psychoactive Medications/Drugs (all mood or mind altering substances) for a minimum of 14 days. Γ **YES** Γ **NO**

Date of last use of Alcohol and/or Drugs: ______________________________

A copy of recent lab work, if available, would be appreciated (e.g. CBC, liver, FBS, etc.).

ADDITIONAL COMMENTS: ______________________________
____

I have examined this client and find him/her to be fit to attend Alcohol & Drug Treatment.

______________________________ ______________________________
PHYSICIAN'S SIGNATURE **DATE**

NAME OF DOCTOR: ______________________________

ADDRESS: ______________________________

PHONE #: ______________________ **FAX #:** ______________________