



Debwewin

RECOVERY & WELLNESS CENTRE
Rooted In Land and Spirit

CONTACT US

Phone: 1-877-250-HOPE

Email: info@debwewinwellness.ca

Fax: 1-431-815-4898

REFERRAL INFORMATION

Referring Workers Name: _____ Phone Number: _____

Agency: _____

Address: _____ Email: _____

PERSONAL INFORMATION

Date: _____

Full Legal Name: _____ Preferred Name: _____

Date of Birth (MM/DD/YYYY): _____ PHIN # (9-digit): _____

Email: _____ Phone Number: _____

Address: _____ Treaty Number: _____
(if applicable)

Indigenous Band: _____ Pronouns: _____

Languages Spoken: _____ Gender Identity: _____

Marital Status: _____

Employment History (list most recent positions and dates):

EMERGENCY CONTACT

Emergency Contact Name: _____

Phone Number: _____ Relationship to Applicant: _____

Partner's Name (if applicable): _____

Worker's name and contact info: _____

[illegible]

MEDICAL & MENTAL HEALTH

Physician or Nurse Practitioner's name and contact info:

Name: _____

Phone Number: _____

Address: _____

Fax: _____

Email: _____

Currently pregnant? If yes, estimated due date: _____

Do you have any current or past medical conditions? If yes, please list, as well as any recent surgeries or hospitalizations with approximate dates.

Please list all current medications:

Any allergies?

Please attempt to bring a two-week supply of medications in their original packages.

Do you experience suicidal ideation? Y / N

Have you ever attempted to take your own life? Y / N

If yes please describe briefly, with age, approximate date and circumstance

List any mental health diagnoses with date, name of Physician, and location:

Hospitalization history for mental health:

History of self-harm (unrelated to substance use):

TREATMENT HISTORY

Have you attended a treatment centre before? List name(s) and date(s) of other facilities attended:

Our treatment lengths starts at 30 days. There is also the option to attend for 45, 60, 90, and 120 days or longer if needed. How long do you estimate your stay will be? This can be changed as needed.

LEGAL INFORMATION

Do you have any upcoming court dates, legal obligations, or probation/parole requirements that you will need to attend or comply with during your stay?

If yes, please provide details (including dates, probation officer or caseworker contact information if applicable):

PAYMENT INFORMATION

Debwewin Recovery & Wellness Centre is a private facility. This means that payment is required through one of the following options: Band or Treaty coverage, third-party insurance, or private payer. Please ensure arrangements are made prior to intake. Our team is available to assist with coordinating coverage if needed.

CONSENT & SIGNATURES

I understand that I may be required to provide a "Medical Clearance for Treatment" form before entry.

I consent to Debwewin Recovery & Wellness Centre staff discussing my application with my referring agent (if applicable).

Applicant's Signature: _____ Date: _____

STAFF USE ONLY

Is applicant suitable for placement? Yes / No

If not suitable, reason:

Alternative services recommended:

Staff Signature: _____ Date: _____