



**CONTACT US**

Phone: 1-877-250-HOPE

Email: info@destinywellness.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: \_\_\_\_\_



# 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.

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Please list all current medications:

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Any allergies?

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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

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

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Hospitalization history for mental health:

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

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## TREATMENT HISTORY

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

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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.

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## LEGAL INFORMATION

Do you have a criminal record? If so please list details:

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## PAYMENT INFORMATION

Destiny 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 Destiny Recovery & Wellness Centre staff discussing my application with my referring agent (if applicable).

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## STAFF USE ONLY

Is applicant suitable for placement? Yes / No

If not suitable, reason:

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Alternative services recommended:

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Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_