Enaahtig Healing Lodge & Learning Centre

INITIAL CONTACT PACKAGE (ICP)

Date of Contact: _____ In person: ☐ Telephone ☐ Other: _____

Completed by: _____

Referral Source ☐ Self ☐ External Agency:

Referring Agency: _____

The information requested is strictly voluntary however it will better guide the development of your plan of care

DEMOGRAPHIC INFORMATION

Client Name: _____ Gender: _____

Date of Birth M/D/Y: _____ Full Address: _____

Phone Number: _____ _____

Cell/Alternate: _____ _____

Mailing Address if different from above: _____

Email: _____ _____

Can we leave: Voice Message ☐ Text Message ☐ Email ☐ Other ☐ _____

If under the age of 18 name of parent or guardian _____

Phone number: _____

Emergency Contact information: _____

Self-Identification: First Nation ☐ Metis ☐ Inuit ☐ Non-Status ☐ Other ☐ _____

Identification Checked: _____

Are you a descendant or Residential School survivor: Yes ☐ No ☐ Unknown ☐

Name of Residential School if known _____

Enaahtig Healing Lodge & Learning Centre

Do you have a family member or friend that is currently employed with Enaahtig Healing Lodge and Learning Center or any of its divisions? Or have you ever been employed with Enaahtig Healing Lodge or any of its divisions.

Yes ☐ ☐ No I am an employee of Enaahtig Healing Lodge

Yes ☐ ☐ No I have a family member or friend who is employed with Enaahtig Healing Lodge

FAMILY COMPOSITION

Relationship status: Single ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐

Widowed ☐ In a relationship ☐ N/A ☐

Children: Yes ☐ No ☐ Only applicable for youth siblings: Yes ☐ No ☐

Are the children in the care of the parents: Yes ☐ No ☐ If no please provide information below:

_____

_____

Please provide date/s of apprehension applicable: _____

_____

_____

Name	Gender	Relationship	DOB	Address only applicable for youth application

Enaahtig Healing Lodge & Learning Centre

EDUCATION AND WORK HISTORY

Education: ☐ Elementary _____

☐ Secondary _____

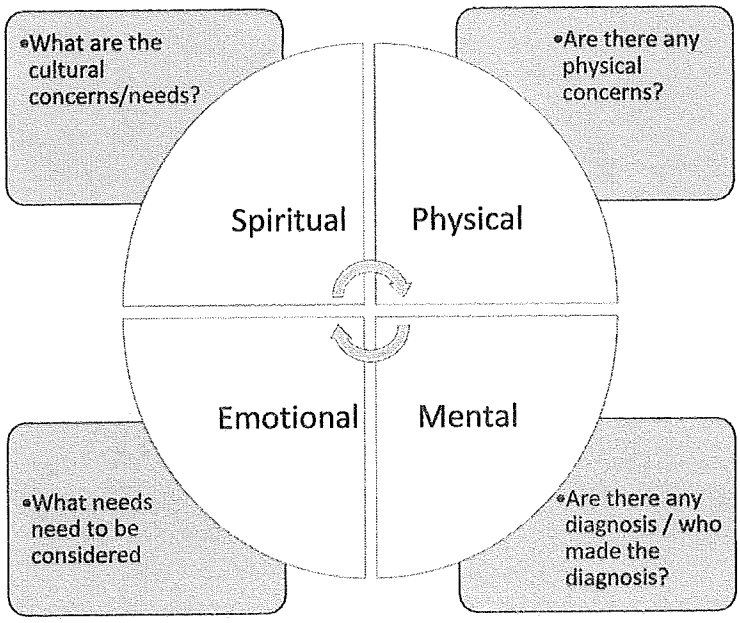
☐ Post-Secondary _____

Income: ☐ Employed ☐ Ontario Works ☐ ODSP ☐ Unemployed ☐ Other

Employer: _____

When completing the presenting issue please ensure to provide as much information as possible.

PRESENTING ISSUES



_____

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Medications	Dosage	Length of Use	How is it administered

Allergies:_____

_____

_____

Diagnosis and date of diagnosis:_____

_____

_____

_____

_____

LEGAL COMPLICATIONS

To include any legal guardian information and terms of care agreement if applicable

_____

_____

_____

_____

_____

_____

_____

Enaahtig Healing Lodge & Learning Centre

Current Community Supports

- ☐ Community Program
- ☐ Justice
- ☐ Child welfare
- ☐ School Board
- ☐ Health Practitioner
- ☐ Counselling/ Therapy
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Have you made referrals to any other community supports? Yes ☐ No ☐

If yes, please list other referrals: _____

_____

_____

_____

For Intake Complete:

Date Received;_____

Intake Assessment Date:_____

Other referrals made:_____

Program Eligibility: ☐ Yes ☐ No

Enaahtig Locations:

Enaahtig Central	Enaahtig Outreach	Enaahtig North	Enaahtig Justice
4184 Vasey Rd	334 West Street	Box 7	808 Yonge St
Victoria Harbour	Orillia, ON	Alban, ON	Midland, ON
L0K 2A0	L3V 5E3	P0M 1A0	L4R2E7
705.534.3724	705.330.4059	705.857.3818	705.526.2929
Fax: 705.534.4991	Fax: 705.330.4067	Fax: 705.857.3818	Fax: 705.526.7557

Enaahtig Healing Lodge & Learning Centre

CONSENT FOR REFERRAL/INTAKE

Statement of Understanding and Consent

I, understand that by signing this form I have acknowledged consent to receive services and attend programming from Enaahtig Healing Lodge and Learning Centre I have read and understand the information provided and that have given my permission to have an intake interview conducted in order to offer services. Furthermore, I understand that this in no way obligates me to Enaahtig Healing Lodge and Learning Centre. Furthermore, I consent to my information being shared with the different services within Enaahtig Healing Lodge and Learning Centre including Enaahtig Outreach Mental Health Team, Enaahtig Justice Team, Enaahtig Therapist Team and Enaahtig Residential Programming Team when needed for my plan of care.

(If consenting for a minor child, please indicate child's name on the right)

_____	_____	_____
Client's Signature	Month / Day / Year	Child's name

_____	_____
Witness	Month / Day / Year

If you are signing for a minor child/ward, what is your relationship with the child/ward?

_____

Enaahtig Healing Lodge & Learning Centre

LIMITS OF CONFIDENTIALITY

Enaahtig Healing Lodge and Learning Centre staff will explain the following information to you. Your signature indicates that you understand and accept the limits of confidentiality. Please feel free to ask any questions you may have pertaining to confidentiality and we will be happy to explain this form and the limits to confidentiality.

Sharing Information

I understand that Enaahtig Healing Lodge and Learning Centre will be asking me for personal information and personal health information to ensure alignment of services. The purpose of the assessment is to develop a plan of care that will support my goals, wellness and recovery. This information will be used to develop a plan of care that may include internal or external referrals and collection of information. This information will be kept in both a hard file as well as an electronic file. Enaahtig Healing Lodge uses a web -based client file system (Emhware) for the creation and storage of client clinical data. This system requires a username and unique individualized password that are provided only to the Enaahtig Healing Lodge staff member.

No individual outside of Enaahtig Healing Lodge and Learning Centre will have access to these files without your written consent. Furthermore, consent can be withdrawn at any time with a written request. Enaahtig clients can request to access their own personal health records by submitting a written request to the Intake Coordinator, or Case Manager.

I also understand that there are circumstances where confidential information is legally required to be shared without my written consent. They are as follows

- **When a client is not capable of giving consent**
- **If we believe that you are in immediate threat to self or others, we are obligated to report this to the proper authorities for the protection of all involved**
- **We are required by law to report sexual abuse by another regulated health professional**
- **Suspected or known abuse of a child 16 years of age or under "current"**
- **In addition, files can be subpoenaed by the court**

_____	_____	_____
Client Name (Please print)	Signature	Date M/D/Y
_____	_____	_____
Witness (Please print)	Signature	Date M/D/Y

THE PERSONAL INFORMATION ACT

The Personal Health Information Protection Act, 2004 is a provincial law that governs the collection, use and disclosure of personal health information within the health care system. The object is to keep personal health information confidential and secure, while allowing for the effective delivery of health care services. Under this legislation, health care providers and others who deliver health care services are collectively known as health information "custodians."

What is personal health information?

Personal health information includes any identifying information about an individual's health or health care history, such as your family medical history, details of a recent visit to your doctor, or your Ontario health card number.

Do health information custodians need my permission to access my personal health information?

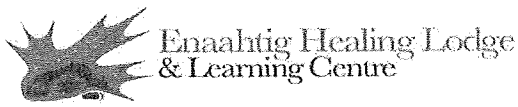
Custodians are permitted to collect, use and disclose your personal health information, on the basis of implied consent, for providing your health care.

What are heath information custodians required to do?

Under PHIPA, health information custodians are required to: 1) collect only the information they need to do their job 2) take steps to safeguard your personal health information 3) take reasonable steps to ensure your health records are accurate and complete for the work they do 4) provide a written description of the practices they use to protect your information, and the name of the person to contact if you have any questions or concerns about your personal health records. What are your rights under PHIPA?

PHIPA gives you the right to: 1) give permission (consent) to how your personal health information is collected, used and shared 2) request access to your health records 3) make corrections to your records.

For more information of your personal health information rights under PHIPA: Service Ontario Information Line: 1-866-532-3162 (Toll-free)



PERSONAL INFORMATION AND CONSENT NOTICE

This Notice and Consent is intended to inform you how we will collect, use, disclose, and destroy your personal information.
Your personal information may be collected formally, in writing, and informally.

Only necessary information will be collected about you. We will collect, use, and disclose information about you for the following purposes:
To develop plans of care and practice case management of your file;

To enable accurate referrals are made;

For anonymous statistical analysis of programs and services.

The storage, retention, and destruction of your personal information complies with this agency's policy, applicable legislation and privacy protection protocols. We are willing to provide a copy of our policy to you at your request.
Your consent may be withdrawn at any time by written notice to this agency.

You may access you own personal information or request corrections through a written request to this agency.

This consent form will serve for all agency programs you access, with one program designated as your primary provider and your original consent kept in that program file.

INDIVDUAL CONSENT

Always complete this part if the Individual is capable of consent. Individual refers to "client."

I, _____ ("The Individual") have read and understood the preceding. Notice and had it explained to me. I am aware how this agency will use my personal information. I am also aware of the steps taken by this agency to protect my information, when it is collected, used or disclosed as well as how it will be stored and destroyed. I consent to the provisions of the preceding Notice.

Signature: _____ Date: _____

Witness: _____ Date: _____

Complete this part if the person is under the age of 16 years or if a substitute, decision maker has been named. See appendix A (please provide proof that you are named substitute decision maker for persons list above)

I am the _____ (parent, guardian, surety, etc.) of the individual. I have read and understood the preceding notice and had it explained to me. I consent on behalf of the individual to the provisions of the preceding notice.

Signature: _____ Date: _____

Name: _____ Witness: _____

Enaahtig Healing Lodge & Learning Centre

CONSENT TO EXCHANGE OR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (Name) consent on behalf of ☐ myself

☐ Or _____ (Name of child if consenting for a minor) to the exchange/ and or release of personal information collected about the above named persons. I authorize employees of Enaahtig Healing Lodge and it divisions to share personal information collected about me and or the name child above to the selected agencies below. I have initialed beside those service providers/ agencies that I agree may share my personal information. For the purpose of assessment for programs and services, also for the purpose of ongoing treatment of my family and myself I understand that I may withdrawal my consent at any time by providing notice in a written withdrawal request.

☐ Barrie Native Friendship Centre
☐ Barrie Area Native Advisory
☐ Beausoleil First Nation Health Centre
☐ Biminaawzogin Regional Aboriginal Women's
☐ Canadian Mental Health Association
☐ Catulpa Community Living Supports Services
☐ Chippewa's of Rama Community Mental Health and Family Services
☐ CSC Chigamik
☐ Crown Attorney
☐ Community Living
☐ David Busby Street Centre
☐ Dnaadgawenmag Binnoojiiyag (DBCFS)
☐ Defence/Duty Counsel
☐ Elizabeth Fry Society
☐ Georgian Bay Native Friendship Centre
☐ Georgian Bay Native Women's Association
☐ Metis Nation of Ontario
☐ Orillia Native Women's Group
☐ Ontario Works
☐ Ontario Disability Support Program (ODSP)
☐ Salvation Army
☐ S.U.N Housing
☐ Simcoe/Muskoka Family Connexions
☐ Probation/Parole
☐ Waypoint Centre for Mental Health Care
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____

_____ _____

Name_____ Date _____

Witness_____ Date_____

APPENDIX A

The definition of a substitute decision maker:

The Substitute Decision Act (SDA) is a law that governs what may happen when someone is not mentally able to make certain kinds of decisions. The Act covers financial or property management decisions, and decisions about personal care, which include health care, food, housing and safety.

A person who makes decisions for another person is called a "substitute decision-maker"

Ranking for the Substitute Decision Maker

- The ranking of the substitute decision maker is as follows (from highest ranked to lowest ranked)
- A court appointed guardian or the person
- A person who has been appointed attorney for personal care. The Client would have signed a document appointing the substitute to act on the client's behalf in health care matters if the client became incapable
- A person appointed by the Consent and Capacity Board to make a health decision in a specific matter.
- The spouse or partner of the client. A partner can include a same sex partner. It may also include a non-sexual partner(e.g. two elderly sisters living together)
- A child of the client or a parent of the client or the Children's Aid Society who has been given the ward ship of the client.
- A parent of the client who does not have custody of the client.
- A Brother or sister of the client.
- Any other relative
- The Public Guardian or Trustee if there is no one else.
- If there are two equally ranked substitute decisions makers (e.g. two sisters of the client) and they cannot agree, the Public Guardian and Trustee may then make the decision.