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 ☐ _____________

Band and Status Card Number if applicable: ____________________________________

Health Card number: ____

Identification Checked: ____

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

Name of Residential School if known __________________________

Enaahtig Healing Lodge
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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 ☐

If adult application is there Children: Yes ☐ No ☐

If applicable does the youth have 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 if different from applicant

Enaahtig Healing Lodge & Learning Centre

EDUCATION AND WORK HISTORY

Education: ☐ Elementary ____________________

☐ Secondary ____________________

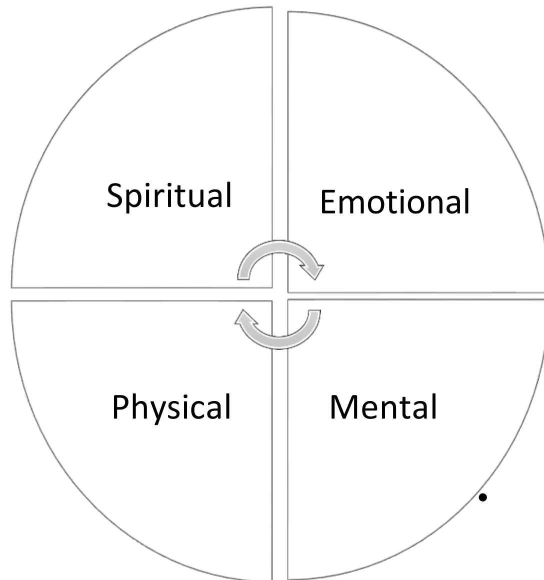
☐ Post-Secondary ____________________

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

Employer: ____________________

When completing the presenting issues portion please provide as much detail as possible

PRESENTING ISSUES



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MEDICAL INFORMATION

Are there any formal diagnosis? Please provide supporting documentation to the diagnoses.

____

____

____

Medications	Dosage	Length of Use	How is it administered

Are there any side effects of the medication we should be aware of? ______________________________

____

____

Allergies:____

____

____

LEGAL COMPLICATIONS

Including past offences. Please also to include any legal guardian information and terms of care agreement if applicable

____

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____

____

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: 705.857.3266	Fax: 705.526.7557

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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

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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)

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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.

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INDIVIDUAL 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. (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: __________________________

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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. (please initial beside applicable consents)

___ 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_______________________________