INITIAL CONTACT PACKAGE (ICP)

Date: In person ☐ Telephone ☐ Other:

Information provided by (check all that apply): ☐ Client ☐ Guardian ☐ Worker

Referral Source ☑ Self ☐ External Agency Referring Agency

Name of Worker: Completed by:

Contact information of worker:

DEMOGRAPHIC INFORMATION

Client Name: Gender: Pronouns:

Date of Birth M/D/Y: Full Address:
Street #/name
Town/City
Postal Code

Phone Number:

Cell/Alternate:

Mailing Address if different from above:

Email:

Permission to: Phone ☐ Text Message ☐ Leave Message ☐ Email ☐

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

Phone number:

Emergency Contact information if no emergency contact please tell us why:

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

First Nation Band if applicable:

10 Digit Status card #:

Health card # & code: Expiry Date:

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

Name of Residential School if known:

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

Yes ☐ ☐ N/A I am an employee of Enaahtig Healing Lodge

Yes ☐ ☐ N/A 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 ☐ Does the youth have any siblings: Yes ☐ No ☐

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

Please provide date/s of apprehension applicable:

HOUSEHOLD COMPOSITION

Name	Gender	Relationship	D/O/B / And Age	Please identify any family members living inside or outside of the home, as well as anyone else living in the home

EDUCATION AND WORK HISTORY

Education: ☐ Elementary

☐ Secondary

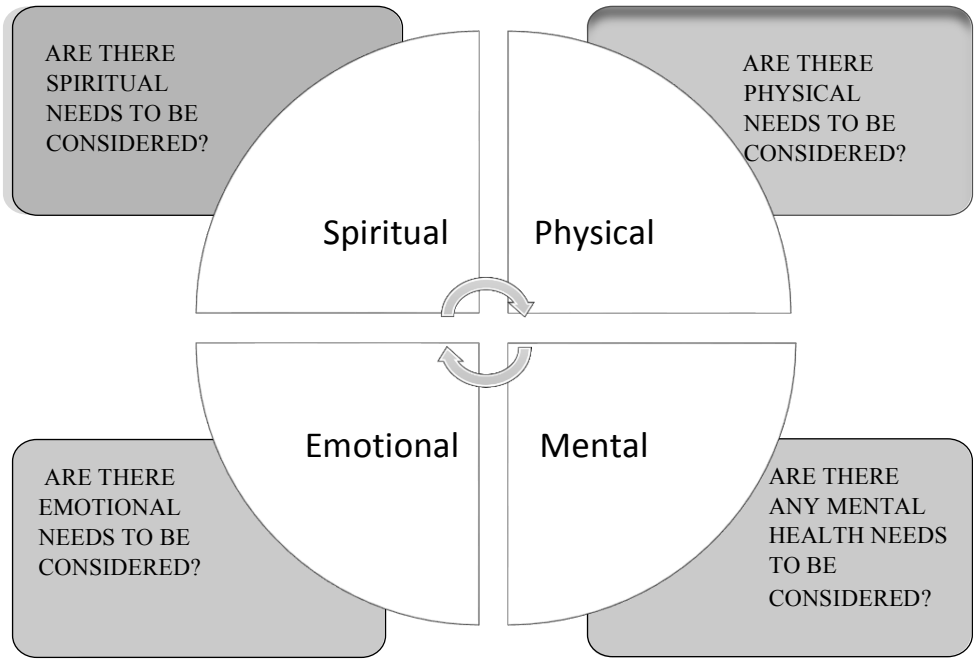
☐ Post-Secondary

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

Employer:

When completing identifying issues please ensure to provide as much information as possible.

IDENTIFYING NEEDS



Spiritual Needs (ex. Your connection to culture, is this something you'd like to improve on?) -

Physical Needs (ex. recent surgeries, mobility issues, upcoming surgeries, self image) -

Emotional Needs (ex. are there any emotions you struggle to carry/express? If so, could you label them? How do you express these emotions to your loved ones? Do you speak them out loud or do you isolate?) -

Mental Needs (ex. do you have any formal mental health diagnoses? Do you suspect you have an undiagnosed mental health barrier/diagnosis?)-

MEDICAL INFORMATION

Mental Health Diagnoses/Name of Assessor:
Date of Diagnosis:

Have you had any assessments? If yes, please provide copies: Yes ☐ No ☐

Medications	Dosage	What is it used for? & Last Used	How is it administered

Substance Alcohol, Drug, Cigarettes	Frequency of use	Date last used

Allergies:

LEGAL MATTERS

Do you currently have any court matters before the court or restrictions we need to be aware (probation, peace bonds, etc)? Please include any relevant custody orders or terms of care agreements if applicable:

Have other referrals been made:

Please list :

Which Program is the ICP for: Youth Res. ☐ Therapy ☐ (North Lodge) Family Res./ Trauma Prog ☐ Outreach ☐ Justice ☐

What services are you specifically looking for from Enaahtig Healing Lodge & Learning Centre:
Please list all services and what you hope to achieve from referral:

Referrals been made either by fax listed below or by email for the following:

Youth Healing Lodge - Sheri Jennett-Wirsching at: youthlodgeintake@enaahtig.ca
North Healing Lodge - Meyranie Cauchon at: northlodgeintake@enaahtig.ca
Community Outreach Services - Sarah Sharp at: outreachintake@enaahtig.ca
Community Justice Centre - Patrick Decourcy at: justicepm@enaahtig.ca

Enaahtig Locations:

Youth Healing Lodge
4184 Vasey Road
Victoria Harbour, ON
L0K 2A0
(705) 534-3724
Fax: (705) 534-4991

North Healing Lodge
490 A&B Hwy 607A
Alban, ON
P0M 1A0
(705) 857-3818 (Office)
(289) 821-0131 (Cell)
Fax: (705) 857-3266

Community Outreach Services
334 West Street
Orillia, ON
L3V 5E3
(705) 330-4059 (Office)
(705) 323-8884 (Cell)
Fax: (705) 330-4067

Community Justice Centre
184 Pillsbury Drive
Midland, ON
L4R 0G9
(249) 388-2990 (Office)
Fax: (249) 388-2992

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 for myself or the child/youth listed below. 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)

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?

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.

Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004
(PHIPA)

I, _____ , **authorize** _____
(Print your name) (Print Name of Health Information Custodian)

Date of Birth: _____ Health Card: _____ Ver: _____
(Month / Day / Year)

to disclose

☐ my personal health information consisting of:

(Describe the personal health information to be disclosed)

or

☐ the personal health information of: _____
(Name of Person for whom you are the substitute decision-maker*)

consisting of:

(Describe the personal health information to be disclosed)

to **Enaahtig Healing Lodge and Learning Centre**
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name: Address:

Home Tel.: Work Tel.:

Signature: Date:

Witness Name: Address:

Home Tel.: Work Tel.:

Signature: Date:

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

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.)

I am the: (parent, guardian, surety, etc.) of: . 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.

Name:

Signature: Date:

Name:

Witness: Date: