Metro Vancouver Indigenous Services Society

Suite #100, 2732 East Hastings Street, Vancouver, BC V5K 1Z9
office | 604.255.2394

"Providing Culturally Appropriate Healing to Address Substance Use and Trauma"

Email Form

Or save and attach to your email browser and mail to: intake@mviss.ca

DATE

A.) INTAKE APPLICATION CHECK LIST

Intake Application ☐

Consent to Release Form ☐

Confidentiality Agreement ☐

Participation Agreement ☐

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1.) INTAKE APPLICATION

Form to be completed by Intake/Referral Worker
Name: _____
Referral Agency: _____
Contact Info: _____

Applicant Info:
Last Name: _____ First Name: _____
Date of Birth (DOB): _____ Home Number: _____
Cell Number: _____Email: _____
Community: _____ (i.e. Vancouver, Richmond, North Shore)
Female: ☐ Male: ☐ Two Spirited: ☐ Transgender: ☐
Non-binary: ☐ Sexual Orientation (optional): _____ Other: _____

Ethnicity:
First Nations: Status: ☐ Non-Status: ☐ Metis: ☐ Inuit: ☐
Other: ☐ If Other Please Specify: _____
Status Card Number: _____

Marital Status:
Married ☐ Single ☐ Divorced ☐
Common Law ☐ Separated ☐
Spouses Name (If applicable) _____

Personal health number: _____
Family Doctor: _____
Family Doctor's phone number: _____

Spiritual affiliation(Optional):

Emergency contact: _____
Relationship_____ Phone #_____
Address: _____

Income Status: Employment Insurance____☐____ Income assistance____☐____ Persons with disability____☐____
Pension____☐____ Student_☐_____
Employed _____☐_____ p/t ____☐____ f/t____☐____

Do you have Children in your care, living with you? Yes ____◯____ No____◯____
Do you have children in care? If yes How many/ How long_____
Have you been mandated to attend program? Yes ____◯____ No____◯____
Dependant Status: _____ Present Living Arrangements:

1. **Own Accommodation/Rent____☐____**
2. **In a shelter____☐_____**
3. **Couch surfing ____☐_____**
4. **On the streets ☐**
5. **Other**

Literacy:

Do you require assistance with reading or writing: ◯ Yes ◯ No ◯ Very little

Mental Wellness and substance use and other concerns:

1. Are you using alcohol or drugs? If yes, what types of substances:

1a. Are you open to abstaining for the purposes of this program?

2. Do you want to be referred to a Detox or treatment program? Yes☐ No☐

3. Have you been diagnosed with psychological disorders (i.e. depression, anxiety, bipolar, schizophrenia, PTSD, etc. that required professional counselling?
Yes☐ No☐ If yes, please elaborate:

4. Have you ever been hospitalized for psychological reasons? Yes_____ No_____
If Yes, where_____ When_____ How long_____

5. Have you ever been prescribed medications for a diagnosis? Yes_____ No_____

6. If Yes, do you take your medications as prescribed? Yes_____ No_____

7. If yes, how often do you take your medications? _____

8. Are You in a harm reduction program? If yes, specify which one: _____

9. Have you ever self harmed. (Cutting, burning, gashing) If yes how and how long ago)?

10. Have you ever had suicide Ideation? ◯ Yes ◯ No If yes How long ago?

11. Are you currently having ideation? If yes, do you have a plan?

***Note* We will complete a safety plan with you if you are experiencing suicidal ideation**

Please use the below blank space to discuss more about the wellness issues you are facing (Optional):

Legal History:

1. Are you presently on Parole/Probation? Yes_____ No _____
If yes, Please answer the subsequent questions, if no please carry on to next section:

2. Who is your probation officer (name and phone number)?

3. What are your charges?

4. Have you been convicted of violent offenses? Yes_____ No_____
4a. If yes, what was the offense if it is different then the above?

5. Do you have any pending charges? Yes_____ No_____

6. What is your next court date? _____

7. Are you mandated to attend our program(s)? Y N

Residential School:

1. Have you attended Residential school? Yes_____ No _____

2. If yes, how long did you attend Residential school? _____

3. Have your parents, sibling and/or relatives attended residential school? Yes_____
No_____ Unknown _____ Please specify: _____

4. How long did your parents and/or relatives attend residential school? _____

5. Which school did you attend? _____

6. Which school did your parents attend? _____

7. How has residential school impacted you?

From this list, please tell me what you would like support with: (Pick top 4 only please)

- ☐ **Violence**
- ☐ **Grief**
- ☐ **Sexual abuse**
- ☐ **Childhood abuse**
- ☐ **Physical abuse**
- ☐ **Abandonment**
- ☐ **Shame**
- ☐ **Alcohol**
- ☐ **Drugs**
- ☐ **Prescription drugs**
- ☐ **Gambling**
- ☐ **Sexual addiction**
- ☐ **Mentoring/Coaching**
- ☐ **Life skills training**
- ☐ **Counseling, emotional and/or spiritual support**
- ☐ **Parenting Skills training**
- ☐ **Family support and counselling**
- ☐ **Education activities (like credit recover, tutoring, homework, school, etc.)**
- ☐ **Sobriety**
- ☐ **Sports activities**
- ☐ **Arts activities**
- ☐ **Recreational activities**
- ☐ **Community service or volunteer work**
- ☐ **Cultural service or volunteer work**
- ☐ **Cultural activities/traditional learning/aboriginal programs**
- ☐ **Employment support (resume writing, interview skill, etc)**
- ☐ **Case Management**
- ☐ **Housing Support**
- ☐ **Outreach**
- ☐ **Cultural Identity**
- ☐ **Mental Wellness**
- ☐ **Foster / Adoption**
- ☐ **After care planning**
- ☐ **Other traumas:**

Is this applicant ready for the group healing session? Yes ◯ No ◯ If no, please specify reason and recommendation:_____

List two healing or wellness goals the applicant has:

1.

2.

Applicants signature: _____

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2.) MVISS Confidentiality Agreement

I, _____ agree that I will keep confidential the personal information of other group participants taking part in the MVISS's-Mental Wellness and Substance Use Programs and Services. "Personal information" refers to information that may be used to determine the identity of another group member such as the name of a group member, the name of other family members, home address, or phone number. Taking pictures, video, and posting on social media is not allowed. "What is shared here stays here."

I also understand that once the group and services has been terminated, I must continue to abide by the confidentiality agreement.

Facilitators have the duty to report under the following circumstances:

*If it is made known that a minor, which is defined as a child who is 16 years of age or younger, has been or is at risk of being physically, sexually, or emotionally injured by another individual;
*If it is made known that one of the group members intends to physically, sexually, or emotionally injure another individual
*If it is made known that a group member intends to cause harm on himself or herself; or otheres
*If it is made known that a group member is suicidal and/or homicidal.

I have read and fully understand the information provided above about the risks of this group. I understand that if I break this agreement I may be asked to leave the group. By signing this document, I agree to accept the risks listed in this form.

_____

Signature of Group Member Date

_____

Signature of MVISS Member Date

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5.) Program Participation Form

I, _____ agree to fully and respectfully participate in Metro Vancouver Indigenous Services Society programming and attend on a regular basis. I understand that if I do not respectfully participate the program I will be asked to leave the program. I also agree to respect the other group members, group rules and group facilitators/Elders. I understand that if I fail to do so I will be asked to leave the group indefinitely.

Applicants Signature: _____

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6.) AUTHORIZATION/CONSENT RELEASE INFO.

I, _____(print participants name), __/__/_____ (date of birth) do hereby consent to and authorize MVISS-Mental Wellness and Substance Use Program and/or their staff members to disclose to/receive information for the purposes of continuation, coordination, and continuity of care in the following areas:

Case Management: GP, Psychiatrist, Therapist, Counselor, Social Worker, Primary Case Manager, Mental Health Case Manager, Addictions Case Manager. Other Case Management: _____

- Verbal, phone, or written communication
- Transfer of Care
- Second Opinion/Referral/Assessments
- Hospitals: Emergency Room Visits, Hospital Stays
- Parole Officer
- Family Counselor
- Housing Worker
- Outreach Worker
- Other_____
- Other_____
- Other_____

I understand that specific information to be disclosed includes the following, and I have the right to inspect and receive copies of the material to be disclosed if I so choose.

I also acknowledge my admission and participation in the MVISS Program(s)
Verbal exchange of information to review (verbally and/or in writing) status in treatment and/or for services
Progress Report (written or verbal)
Physical Exam/History Psychological Exam/History Social History (Summary only)
Psychiatric Evaluation
Discharge Summary
Aftercare Plan
Other (Please specify): _____

I also understand that this consent may be revoked at any time. This consent will remain in force for one year from date of signature or until I cancel this authorization in writing.

This authorization for Release of Information has been fully explained to me and I understand the contents and purpose.
Signature of Client: _____
Date: _____
Signature of Witness Date: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION
● Right to receive copy of this authorization – I understand that if I sign this authorization, I will be provided with a copy of this authorization. ● Right to withdraw this authorization – I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact MVISS-Mental Wellness and Substance Use Program. I understand that my cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have made prior to the receipt of my cancellation form.

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