BELLWOOD
PART OF THE EDGEWOOD HEALTH NETWORK

BELLWOOD ASSESSMENT APPLICATION

Bellwood's Assessment Application package includes the following items:

(1) Confidentiality and Exceptions to Confidentiality
(2) Privacy Notice and Consent Form
(3) Assessment Application

Please review and sign (in the presence of a witness), forms (1) and (2) *before* completing the Assessment Application. If you have any questions regarding either consent, please contact our Intake & Admission Department at 416-495-0926 or 1-800-387-6198.

Confidentiality and Exceptions to Confidentiality

Bellwood Health Services Inc. is based on the principle of a caring and supportive community, where trust and safety facilitate successful treatment and recovery. To attain these goals, all participants are required to understand and follow these guidelines to ensure confidentiality. This means that no person entering this facility shall reveal or speak of conversations between or about clients, or disclose the identities of our clients, in any manner, outside of this building. It is the policy of Bellwood Health Services to maintain the confidentially of our clients and all client information. We will not willingly disclose information we obtained in confidence, unless ethically required by Bellwood or the legal system, i.e., subpoena or search warrant, or through mandatory reporting such as the Children's Aid Society and Ministry of Transportation.

Limits to Confidentiality and Duty to Warn

Child Abuse – Bellwood is mandated by law to report to the Children's Aid Society *any* disclosure or suspicion of child abuse or neglect, or *any* belief or suspicion that a child is in need of protection or is at risk.

Sexual Abuse – Bellwood is mandated to report the name of healthcare professionals to their respective colleges if there is reason to believe that they have engaged in sexually inappropriate behaviour (sexual abuse) with their patients.

Note: As other laws come into effect, we will follow them as required.

Prevention of Harm

Bellwood reserves the right to disclose what would otherwise be confidential information if we have reason to believe that it is necessary to prevent death or grievous bodily injury to you or a third party.

In addition to the above, it should be noted that Bellwood has adopted a team approach to client care. That is, it is our practice to share information among the professional staff to ensure the highest quality of care.

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Please complete and have witnessed:

I, _____ (print name), hereby confirm that I have read and understand Bellwood's policy on Confidentiality and Exceptions to Confidentiality, and agree with its terms.

Client Signature: _____ Date: _____

Witness Name: _____

Witness Signature:_____ Date: _____

Privacy Notice and Consent Form

Bellwood Health Services Inc. provides you with a broad variety of care services. To meet your needs and serve you well, we need to know personal information about you. You, as an individual, have a right to know how we collect, use and disclose personal information. You have a right to expect that, to the best of our ability, your personal information held by us remains accurate, confidential and secure. Bellwood Health Services Inc. is proud of its long-standing commitment to maintaining the confidentiality and security of personal information and has implemented practices to better protect the privacy of your personal information.

Privacy Policies and Procedures

In order to ensure that your personal information is collected in a secure and confidential manner, strict policies and procedures have been implemented at Bellwood that must be followed at all times by both staff and clients. Our organization's privacy policies and practices are readily available at your request.

What Information We Collect and How We use Your Information

Bellwood Health Services Inc. collects, uses, discloses and stores facts about you and your health. However, we limit the collection of personal information to what is required for administration and healthcare purposes. This includes information such as name, age, weight, health card number, medical history and any current and past addictions or behavioral problems. This information is important for your assessment and diagnosis and will be shared among your treatment team during your rehabilitation. Throughout treatment, any laboratory tests, new findings and new treatments implemented will be recorded. Certain information may be recorded on file for demographic purposes, quality improvement and research analysis.

Who Has Access to Your Information?

At Bellwood we are accountable for all of the information we collect. We share your information on a strict need to know basis. Your personal information will not be disclosed to anyone who is not directly involved in your care and treatment, unless you give permission or is required by law. These people may include:

- Yourself
- Your healthcare providers within Bellwood
- Our interns and professional trainees
- Service providers under contract to Bellwood

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How Your Information is Protected

- All information we hold is securely safeguarded
- We will keep your information as accurate, complete and up to date as possible
- Your information is used and disclosed only for the purposes for which it was collected, and is retained only as long as it is required to fulfill its purpose

Your Rights

At Bellwood we respond to your questions and concerns. We have appointed a Chief Privacy Officer who is responsible for all of your privacy issues. Please feel free to contact our officer at (416) 495-0926.

Federal Privacy Legislation – The Personal Information Protection and Electronic Documents Act (PIPEDA) 10 Key Principles:

- Accountability
- Consent
- Limiting Use
- Safeguards
- Individual Access
- Identifying Purposes
- Limiting Collection
- Maintaining Accuracy
- Openness
- Challenging Compliance

Please complete and have witnessed:

I, _____ (print name), hereby confirm that I have read and understand Bellwood's Privacy and Consent Form, and agree with its terms.

Client Signature: _____ Date: _____

Witness Name (print): _____

Witness Signature:_____ Date: _____

If faxing back assessment application, please indicate:

☐ **Yes, I have an assessment booked at Bellwood**

Date: _____

Time: _____

Counsellor's Name: _____

☐ **No, I would like to receive a call to book an assessment**

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FOR OFFICE USE ONLY
Client #: _____ Inquiry #: _____ Program #: _____
Program Name: _____ ☐ BTHC ☐MOH
CF Base (if applicable) _____

ASSESSMENT QUESTIONNAIRE (please print clearly)

Name: _____
First Middle Last

Gender: ☐ Male ☐Female **Date of Birth:** _____/_____/_____ **Age:** _____
Month Day Year

Address: _____
Street

_____ _____ _____
City Province Postal Code

Tel: H ( ) _____ **W** ( ) _____ **C** ( ) _____
☐ Voicemail OK ☐ Voicemail OK ☐ Voicemail OK

Email: _____ **Preferred Method of Contact:** ☐ Email ☐Phone
☐ Email OK

Emergency Contact: _____ **Phone:** ( ) _____

Relationship: _____

Address: _____
Street

_____ _____ _____
City Province Postal Code

Health Card #: _____ **Version Code:** _____

Who referred you to Bellwood? ☐ Self ☐ Other Name of Referent: _____

Have you been in the Military? ☐ No ☐ Yes If "**YES**", when and where did you serve?
_____

Your Occupation: _____ Name of Employer: _____

Did your employer *initiate* the referral? ☐ No ☐ Yes

Is coming to treatment a condition of continued employment? ☐ No ☐ Yes

Who will be funding your treatment? _____

Insurance Company (if applicable): _____

Person insured: _____ Date of Birth: _____/_____/_____
Month Day Year

Group Policy #: _____ Certificate #: _____

FOR OFFICE USE ONLY
Room Coverage: W ___ S ___ P ___ O/P _____ Previous Bellwood Client? ☐ No ☐ Yes
Assessment Date (m/d/y): _____/_____/_____ Assessment Counsellor: _____
Admission Date: _____/_____/_____ Re-admit Date: _____/ _____/ _____
Day Status Trans:_____/_____/_____
Discharge Date: _____/_____/_____ Discharge Type (AMA, etc.):
Bellwood MD: _____ ☐ Self-Pay ☐ Reciprocal ☐ Employer

Education: _____

Is English your second language? ☐ No ☐ Yes

If not employed, source of income: ☐ Pension ☐ Disability ☐ Other Income

Financial concerns: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-Law

Living arrangement: ☐ Alone ☐ With others (specify): _____

Are housing arrangements safe and stable for your recovery? _____

Children (if applicable): Gender/Age: _____ Gender/Age: _____

Gender/Age: _____ Gender/Age: _____

Do you have any religious observances that need to be considered (e.g. religious holidays, celebrations, prayers)? ☐ No ☐ Yes

If "**YES**", specify: _____

Is there anything that would prevent your participation in treatment at this time (e.g. work, travel, family, money)? ☐ No ☐ Yes

If "**YES**", specify: _____

In your estimation, do you live with someone who abuses alcohol or other drugs?

☐ No ☐ Yes If "**YES**", what substance(s)? _____

Is there a family history of addiction or mental health issues? ☐ No ☐Yes

If "**YES**", please identify: _____

_____

_____

In your estimation, do you live with someone who has a behavioural addiction (e.g. eating disorder, sex addiction or gambling addiction)? ☐ No ☐ Yes

If "**YES**", what is the behavioural addiction? _____

_____

A. ALCOHOL & DRUG USE

Psychoactive Drug Use

ORDER of substance use/abuse	Substance Type	At what age did you start using?	How long has this been a problem for you?	What is the average quantity of use? (i.e. 3–7/week)	Approx. how much did you use in the last month?	When was your last use & how much?	COMMENTS
	Alcohol						
	Crack/Cocaine, Amphetamines, Stimulants, Crystal Meth & other (Ecstasy)						
	Cannabis						
	Benzodiazepines (Valium, Xanax, Ativan, Clonazapam) Sedatives & Hypnotics						
	Heroin/Opium , Opioids (Tylenol 2,3,4, etc.) Codeine Preparations (Oxycontin, Percocet, Morphine)						
	Tobacco						
	Others						

1. Have you ever had a seizure? ☐ No ☐ Yes _____
2. Have you ever been hospitalized or 'detoxified' as a result of excessive use? ☐ No ☐ Yes
   _____
3. Would you describe your withdrawal symptoms as mild, moderate, or severe? Please describe: _____
4. Do you believe you require supervised detoxification or can you manage your withdrawal independently? ☐ No ☐ Yes If "**YES**", please describe: _____
5. Have you ever been in counselling or treatment for <u>any</u> addiction or compulsive behaviour?
   ☐ No ☐ Yes (see chart below)

Name of Service Provider	Approximate dates of treatment	Length of stay (treatment days) or length of time seeing professional (i.e. weekly for 2 years)	Outcome following treatment (Positive or negative experience)

B. PHYSICAL & MENTAL HEALTH

1. Family Physician:_____ Consent to contact: ☐ No ☐ Yes
   Tel: ( ) _____
   Address: _____

   Other Healthcare Professional: (i.e. psychiatrist, medical specialist)
   Name: _____ Consent to contact: ☐ No ☐ Yes
   Tel: ( ) _____
   Address: _____

2. Is your family physician/healthcare professional aware of your addiction and/or compulsive behaviour? ☐ No ☐ Yes
3. Are there any activities that you may require assistance with mobility: bathing, walking, up/down stairs? ☐ No ☐ Yes If "**YES**", please explain: _____
   _____
4. Are you visually or hearing impaired? _____
5. **Medical:**
   a) Do you have any dietary restrictions or special requirements: ☐ No ☐ Yes
      If "**YES**", please specify_____
   b) Please list all allergies, including food allergies (medical documentation may be required):
      _____
   c) Please list all current physical health conditions including surgeries, hospitalizations and any recent diagnosis, etc.

	Condition	Details
1.		
2.		
3.		

   d) Can you recall your last medical assessment? ☐ No ☐ Yes (Date: _____)
   e) Do you have any upcoming medical appointments: ☐ No ☐ Yes (Date: _____)
   f) Height: _____ ☐ ft ☐ cm Weight: _____ ☐ lbs ☐ kg

g) Are you currently taking any prescribed medications? ☐ No ☐ Yes
If "**YES**", please specify below:

Medication	Dosage	Purpose	Medication	Dosage	Purpose

g) Do you have chronic pain management issues? ☐ No ☐ Yes
If "**YES**", please specify: _____

h) Are you currently prescribed methadone/suboxone or any other opioid substitute?
☐ No ☐ Yes If "**YES**", please specify: _____

i) Have you ever been told you have a communicable disease (i.e. TB, MRSA, VRE, Hepatitis, HIV or C Difficile)? ☐ No ☐ Yes If "**YES**", please specify: _____

6. **Mental Health:**

Have you been treated/hospitalized with a mental health issue(s) by a qualified mental health professional? ☐ No ☐ Yes

a) What was the diagnosis: _____

b) When were you treated: _____

	By Whom?	Where (location)?	Diagnosis/ Outcomes/ Comments
Within the last month			
Within last 12 months			
Within a lifetime			

7. **Physical, Sexual and Emotional Trauma:**

1. Have you ever been sexually, physically or emotionally abused? ☐ No ☐ Yes

If "**YES**", please specify: _____

8. **Risk of Harm to Self or Others:**

a) Do you have a history of suicide attempts or self-harm (i.e. cutting, self-mutilation)?

☐ No ☐ Yes If "**YES**" were you under the influence of a substance at the time?

☐ No ☐ Yes If "**YES**", please explain: _____

C. EATING

1. Are you satisfied with your eating patterns? ☐ No ☐ Yes
   If "**NO**", please explain: _____
2. Do you ever eat in secret? ☐ No ☐ Yes
   If "**YES**", please explain: _____
3. Does your weight affect how you feel about yourself? ☐ No ☐ Yes
   If "**YES**", please explain: _____
4. Do you suffer with, or have you ever suffered in the past with an eating disorder? ☐ No ☐ Yes
   If "**YES**", please explain: _____
   _____
5. Do you have any further comments on your eating habits? _____
   _____

D. SEXUAL

1. Do you find yourself preoccupied with sexual thoughts and activities (i.e. pornography, escort services, extramarital affairs etc)? ☐ No ☐ Yes
   If "**YES**", please specify: _____
2. Do you feel have concerns about your sexual behaviour? ☐ No ☐Sometimes
   Please describe: _____
   _____

E. GAMBLING

1. Do you have any concerns about gambling (e.g. running up large debts, betting on sports, purchasing lottery tickets, playing bingo)? ☐ No ☐ Yes
   If "**YES**", please explain: _____

F. LEGAL

1. Is attending treatment the result of a court order? ☐ No ☐ Yes
2. Have you ever been charged with an offence involving violence ☐ No ☐ Yes
   If "**YES**", please explain: _____
3. Describe any legal problems: _____
   _____

4. Describe any current/past legal convictions: _____

   _____

5. Do you have any driving infractions? ☐ No ☐ Yes

   If "**YES**", please explain: _____

6. Are you on probation/parole? ☐ No ☐ Yes

   If "**YES**", what are the offences? Please identify any restrictions, conditions/surety, house arrest and restraining orders. Provide copies of legal documentation to assessment counsellor.

   _____

   _____

7. Children's Aid Society issues: ☐ No ☐ Yes

   If "**YES**", please explain: _____

   _____

8. Have other people told you they think you have problem controlling your anger? ☐ No ☐ Yes

   Comments: _____

9. Do you have any upcoming court dates? ☐ No ☐ Yes

   If "**YES**", please explain: _____

   Are there any other issues to add or discuss that may be relevant to your treatment?

   _____

   _____

   _____

   Was there a **<u>precipitating event or crisis</u>** that resulted in this application for treatment? Please be specific:

   _____

   _____

   _____

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Please check off any presenting issues and/or concerns you may have.

✓	Presenting Issue	✓	Presenting Issue
	Accommodation		Sexual Issues
	Marital/Family/Family of Origin		Sexual Identity
	Education/Employment		A.C.A. Issues
	Finance		Co-dependent Issues
	Legal		Grief
	Mental Health Problem		History of Relapse
	Social Isolation		Substance Abuse - Alcohol & Drug
	Developmentally Handicapped		Substance Abuse - Alcohol Only
	Reading/Writing Problem		Substance Abuse - Drug Only
	Physical Health Problem		Substance Abuse -By Significant Other
	Physical Disability		Gambling Abuse
	Physically Abused		Post Traumatic Stress
	Physically Abusive		Self Esteem
	Sexually Abused		Anger Management
	Sexually Abusive		Stress Management
	Eating Disorder		Perfectionism
	Sleep Problems		Leisure Activities
	Suicidal Ideation		Lack Insight
	Suicidal Attempts		Communication Problems
	Relationship Issues		Other

Thank you for completing our Assessment Application. Please return it to us by fax or mail, or bring it with you at the time of your personal assessment.

Fax Number: (416) 495-7943

Mail: Bellwood Health Services
Attn: Intake & Assessment Dept.
1020 McNicoll Ave.
Toronto, ON M1W 2J6

Please note: Level 3 sex offenders (perpetrators of incest or non-consensual sexual behaviour, or individuals who lust after children or have sexually violated children) are not eligible for admission to Bellwood. Should an incident or history of Level 3 sex behaviour (or lust toward children) be disclosed during a client's stay at Bellwood, that individual will be discharged from the program.

I have read and understand Bellwood's policy on Level 3 sex offenders and offences.

_____ Date: ____/____/____
Client Signature Month Day Year

_____ Date: ____/____/____
Assessment Counsellor Signature Month Day Year