RAAM Intake Form

Part 1: General Information

Last Name: _____ First Name: _____ Alternate Name: _____

Language(s) spoken: _____ Interpreter Required: ☐ Yes ☐ No

Address: _____

Are you at risk of losing your housing? ☐ Yes ☐ No

☐Not homeless ☐Homeless no address ☐Shelter ☐ Other temporary shelter:_____

Phone #: _____ Text? ☐ Yes ☐ No Work #: _____

May we leave a message/text? ☐ Yes ☐ No

Date of Birth: _____ Age: _____

Health Card Number: _____ Version Code: _____ Expiry Date: _____

Federal Interim Health #: _____ Other Health Coverage/Insurance: _____

Income source: ☐Employment ☐ Employment Insurance ☐Disability Insurance ☐Family Support

☐ Ontario Disability Support Program ☐Ontario Works ☐ None ☐Other: _____

How did you hear about us? ☐ Emergency Department ☐ Other Health Provider

☐ Website ☐ Newspaper/Media ☐ Other: _____

Primary Care Provider (e.g. Physician or NP): ☐ Yes ☐ No

Name: _____ Location: _____

Pharmacy Name: _____ Location: _____

Allergies:_____(if Yes) Reaction: _____

Current Medications: _____

Part 2: Socio-Demographic Information (Optional – Part 2 only)

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Other _____

Gender Identity: ☐ Female ☐ Male ☐ Other _____

Preferred Pronouns: ☐ she/her ☐ him/he ☐ they/them

Sexual Orientation: ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Queer ☐ Two-Spirit

☐ Prefer not to answer ☐ Other: _____

Racial/Ethnic Group: ☐ Asian ☐ Black ☐First Nations ☐ White ☐ Latin ☐ Mixed Heritage

☐Prefer not to answer ☐ Other: _____

What is your highest level of Education? ☐ Primary (K-8) ☐ Secondary (9-12/13) ☐College

☐ University Bachelors ☐ University Post Grad ☐No formal education ☐Prefer not to answer

How much money do you make in a year? (whole household) ☐ Don't know ☐<$14 999

☐$15 000-19 999 ☐$20 000-24 999 ☐$25 000-29 999 ☐$30 000-34 999 ☐ $35 000-39 999

☐ $40 000-59 999 ☐$60 000 – 89 999 ☐ $ 90 000 – 119 999 ☐ $120 000-149 000 ☐150 000+

How many people help bring in this income? ____How many people are supported by this income? ____

Who lives with you? ☐ Couple with child(ren) ☐ Couple without child(ren) ☐ Sole member

☐ Grandparents with grandchild(ren) ☐ Extended family ☐ Siblings ☐ Unrelated house mates

☐ Single Parent ☐ Other _____

Parenting: Are you parenting, pregnant, or a caregiver for a child under the age of 18? ☐Yes ☐ No

Disabilities: ☐ Chronic illness ☐Developmental Disability ☐ Drug or Alcohol dependence

☐ Learning Disability ☐ Mental Illness ☐Physical Disability ☐Sensory Disability ☐None

☐Other: _____ ☐Do not know ☐Prefer not to answer

Part 3: Admission Information (please check [√] ALL that apply):

What concern are you seeking help for?

☐Alcohol ☐ Drug ☐ Gambling ☐ Gaming ☐ Internet ☐ Unsure/None of the above

How ready are you to make changes to your alcohol/dug/gaming/gambling/internet use? (please circle a number from 1-10)

Not Ready									Ready
1	2	3	4	5	6	7	8	9	10

Please check [√] ONE for each category:

Legal Status: ☐ No Problem ☐ Awaiting Court Date ☐Probation ☐Parole ☐Incarcerated ☐ Other

Young Offender: ☐ Yes ☐ No

Substance Use Concerns: ☐ Yes (please [√] ALL that apply) ☐ No

☐Alcohol (Beer, Wine, Spirits)
☐ Hallucinogens

☐Amphetamines (Adderall, Concerta)
☐Tobacco

☐ Barbituates
☐ Methamphetamines (Crystal Meth)

☐Benzodiazepines (Xanax, Lorazepam, Valium)
☐ Other Psychoactive Drugs

☐Cannabis (Marijuana, CBD)
☐Over-The-Counter Codeine (Tylenol 1)

☐ Cocaine
☐ Opioids (fentanyl, morphine, dilaudid, heroin)

☐ Crack
☐ Steroids

☐ Ecstasy
☐ Glue & Other Inhalants

Gambling Concerns: ☐ Yes ☐ No Comments: _____

Gaming/Internet/Technology Concerns: ☐ Yes ☐ No Comments: _____

Part 4: Health Status (please fill in EACH question [√])

A. **Physical Health Status:** ☐ Vision Impairment ☐Hearing Impairment ☐Mobility/Physical Impairment ☐I am Pregnant

B. **Non-Medical Intravenous Drug Use:** ☐ Never Injected ☐ Injected Prior to 1 year Ago ☐ Injected in the Last 12 months

C. **Have you ever shared equipment?** ☐ Yes ☐ No

D. **Number of overnight hospitalizations in the last 12 months**: _____

E. **Diagnosed with mental health problem by a qualified mental health professional?**
☐ Yes ☐ No Within Last 12 months
☐ Yes ☐ No Within Lifetime

F. **Hospitalized for a mental health problem?**
☐ Yes ☐No Within Last 12 months
☐ Yes ☐ No Within Lifetime

G. **Have you every received counselling/treatment/support for a mental health, emotional behavioural or psychological problem?**

☐ Yes ☐ No Currently

☐ Yes ☐ No Within Last 12 Months

☐ Yes ☐ No Within Lifetime

H. Have you ever been prescribed medication for a mental health problem?

☐ Yes ☐ No Currently

☐ Yes ☐ No Within Last 12 months

☐ Yes ☐ No Within Lifetime

I. Have you ever had seizures? ☐ Yes ☐ No

J. Please list any other health problems (i.e. Blood pressure problems, Cancer, Diabetes, Endocarditis, Heart problems, HIV/AIDS, Hepatitis, Kidney disease, Asthma, Migraine headaches, etc.):

_____

K. Do you have any immediate safety concerns that you would like assistance with today or soon? ☐ Yes ☐No

L. Have you ever had a concerning hit to your head, been hit on the head and/or experienced multiple, repeated impacts to your head?

☐ Yes ☐ No

M. Have you ever been in the emergency room, hospital, or by a doctor because of an injury to your head or neck?

☐ Yes ☐ No

N. Did you ever lose consciousness (including as a result of overdose) or experience a period of being dazed or did you have a gap in memory from the injury?

☐ Yes ☐ No

O. Are you currently taking Naltrexone?

☐ Yes ☐ No

P. Are you currently taking Methadone/Suboxone?

☐ Yes ☐ No

Q. Do you have a Naloxone Kit?

☐ Yes ☐ No

R. Have you ever attended any addiction treatment programs?

☐ Yes ☐ No (If yes, please list):

_____

S. Other information that we should know?

_____

Oxford County Community Health Centre

RAAM OXFORD COUNTY

Consent to Obtain and Release Information

I / We _____

(Name of Client or Substitute Decision Maker)

Of _____

(Address of client or SDM giving consent)

Hereby give consent to the Oxford County Community Health Centre to:

( ) obtain information from (check box)

( ) release information to (check box)

Specify person and/ or agency: (insert pharmacy name and address)

__Pharmacy:_____

_____

In respect of (select at least one):

☐ Client Name: _____ Date of Birth: _____

☐ Child / Youth Name: _____ Date of Birth: _____

For the purpose of (select at least one):

☐ Service Coordination:_____

☐ Other (please specify): _____

Description of Information to be shared (select one):

☐ Anything applicable

☐ Specifically, the following:_____

_____

_____ _____ _____

Signature of Client or SDM **Date** **Signature of Witness**

This consent remains in effect for one year unless otherwise authorized by the client/SDM.

35 Metcalf St
Woodstock,
ON, N4S 3E6
T 519-539-1111
F 519-539-9111

Note: While this consent remains in effect for one year unless otherwise authorized by the client, there are limits to this consent for release of information in the event Oxford County Community Health Centre needs to respond to the legislated requirements for the release of client information. These include but are not limited to: coroner's request, subpoena, search warrant, or court order. Oxford County Community Health Centre's privacy and confidentiality policies are explained to clients during their initial orientation or intake visit and are posted in the Centre's lobby.

Oxford County
Community Health Centre

RAAM
OXFORD COUNTY

Consent to Obtain and Release Information

I/We _____

(Name of Client or Substitute Decision Maker)

Of _____

(Address of client or SDM giving consent)

Hereby give consent to the Oxford County Community Health Centre to:

( ) obtain information from (check box)

( ) release information to (check box)

Specify person and/ or agency: (insert Provider's name and address)

__Doctor/Nurse Practitioner:_____

_____

In respect of (select at least one):

☐ Client Name: _____ Date of Birth: _____

☐ Child / Youth Name: _____ Date of Birth: _____

For the purpose of (select at least one):

☐ Service Coordination: _____

☐ Other (please specify): _____

Description of Information to be shared (select one):

☐ Anything applicable

☐ Specifically, the following: _____

_____

_____ _____ _____

Signature of Client or SDM **Date** **Signature of Witness**

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Oxford County Community Health Centre

Consent to the Collection, Use and Disclosure of Personal Health Information

I, _____, have reviewed the **Oxford County Community Health Centre**'s written statement concerning the collection, use and disclosure of personal health information.

- I understand that the **Oxford County Community Health Centre** is seeking my consent for it to collect, use and/or disclose personal health information given by me or by the person acting on my behalf.

- I understand that the **Oxford County Community Health Centre** will only collect, use and disclose my personal health information with my consent **as set out in the statement of information practices** unless a particular collection, use or disclosure is permitted or required by law without my consent.

- I also understand that I can refuse to sign this consent form. I can also withdraw my consent any time by writing to the **Oxford County Community Health Centre** Privacy Office.

Limitations of Confidentiality: we must release information about you ***without*** your consent:

- If you are threatening harm to yourself or others
- If a child under 16 years of age is/may be at risk of abuse/neglect
- If we are subpoenaed by a court of law or by a judge
- If we are presented with a search warrant

I hereby authorize **Oxford County Community Health Centre** to collect, use and disclose my personal health information for the purposes that I have checked-off above. I understand the limitations to confidentiality. I have been given opportunity to ask questions and answers have been provided to my satisfaction.

Client's Name: _____

Signature: _____Date: _____

Staff Signature: _____ Date: _____
(I have reviewed the above information with the client).

RAAM OXFORD COUNTY

Treatment Agreement

As a participant in medication treatment for opioids or alcohol dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to attend during clinic hours and conduct myself in a courteous manner at all times in the RAAM clinic.
2. I will inform my healthcare team about any prescription and non-prescription medications that I am taking. I agree not to obtain mediation from any doctors, nurse practitioners, pharmacies, or other sources without telling my treating doctor/nurse practitioner.
3. It is my responsibility to keep my medication in a safe and secure place away from children, pets or other adults. If anyone swallows my medication, I will call 911 or my local poison control centre (www.capcc.ca). If I report that my take-home medication supplies have been lost, stolen or runs out early, I understand that my doctor/nurse practitioner many not provide me with a replacement supply, regardless of my reasoning.
4. I agree not to give, lend or sell any take-home medication to anyone.
5. I am aware that I am the only person who may pick up my prescription from the pharmacy.
6. I agree that my medication/prescription can only be given to me during clinic hours. A missed visit may result in not being able to get my medication/prescription until the next available clinic. I understand that at every visit, my doctor/nurse practitioner may ask me about missed doses and unused medication.
7. I agree to take my medication as prescribed. I understand that Suboxone contains naloxone which will cause immediate withdrawal if injected or snorted.
8. I understand that mixing central nervous system depressants such as opioids, alcohol and benzodiazepines can lead to overdose. I have been informed that several deaths have occurred among persons mixing Suboxone and benzodiazepines and I understand the risks associated with treatment.
9. I understand that treatment may require daily trips to the pharmacy and regular visits to my prescriber, which may impact my work, school or other responsibilities.
10. Counselling may improve my success with treatment. I am aware that Addictions Services of Thames Valley offers free addiction counselling for all RAAM clients and Oxford County CHC provides support services by accessing our outreach and social workers.
11. I agree to provide a urine sample for drug screening at every clinic visit.
12. I understand that violations of the above may be grounds for termination or other consequences (i.e. loss of carries).
13. I understand the clinic will not diagnose or prescribe treatments related to other medical issues.

Patient Name (Print) Patient Signature Date

Witness (Print) Witness Signature Date

Copy Provided to patient _____ (Witness Initials)