

# TSOW-TUN LE LUM SOCIETY

## Helping House

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## KWUNATSUSTUL – Trauma Program

### “HOLDING HANDS, STANDING TOGETHER”

#### Residential Second Stage Trauma Treatment Programs:

Name	Program Length	Sobriety Time Required
<i>Kwunatsustul (trauma) Program</i>	<i>5 weeks</i>	<i>6 months</i>
<i>Elders &amp; Colleagues Program</i>	<i>2 weeks</i>	<i>6 months</i>
<i>Honouring Grief</i>	<i>2 or 3 weeks</i>	<i>1 month</i>
<i>Overcoming Abandonment</i>	<i>2 or 3 weeks</i>	<i>1 month</i>

These programs are offered to address unresolved trauma. Our balanced therapeutic programs can assist those who have experienced sexual abuse, unresolved grief, abandonment, survivors of residential school, intergenerational survivors, etc.

Cultural Ceremonies support the healing and discovery of ways to move beyond the trauma of the past.



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# SECTION ONE

## REFERRAL PROCESS

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As the referral person, please follow these procedures:

- Please complete this application package with the applicant. Thoroughly read this Intake Package and complete ALL questions.
- Tsow-Tun Le Lum requires CONSENT from the applicant to allow our staff to contact you as the referral person, or other people who may need to know the status of their application or intake date. Please ensure the applicant completes, signs, and dates the 'Consent for Release of Information' included in this application package.
- Medical personnel must complete the 'Pre-Admission Medical Evaluation' form.
- If the applicant is on probation, please attach a copy of their probation order.
- Fax completed Application Pkg (*include the Pre-Admission Medical Evaluation, and TB test results*) to TTLL. Fax: 250-390-3119
- TTLL intake worker will screen applications on a first-come-first-served basis. The referral worker will be notified via email of any additional information needed to complete the application.
- Once the screening process is complete the referral worker will be notified by email with a potential admission date.
- Ensure applicant has completed any medical and dental appointments prior to treatment. Ensure they have hearing aids and reading glasses if required.
- TRAVEL: Organize and confirm all travel arrangements with the applicant. Intake arrival time is **before 2:00 PM** and clients are responsible for their transportation to and from the Centre. TTLL does not pick up clients from the airport or ferry – please ensure they have taxi vouchers as part of the travel arrangements.



# ADMISSION CRITERIA

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To be admitted to Tsow-Tun Le Lum programs, the applicant must:

1.  be 19 years of age, or older;
2.  be mentally capable and physically able to participate in all aspects of the program;
3.  When applying for our programs program, please do not submit application until the applicant has the required sobriety as outlined on page 1 of this package. This sobriety requirement **includes abstinence from alcohol, illegal or mind-altering drugs, methadone, suboxone, medicinal or recreational marijuana, and all cannabis products containing THC or CBD;**
4.  have no outside appointments to attend during the program such as: social worker, doctor, physiotherapist, dentist, chiropractor, childcare. Please be aware that if you have outside appointments scheduled during the program, you may be ineligible to continue treatment;
5.  not have any legal issues before the courts. Resolution and sentencing must be complete prior to referral;
6.  If charged with a sexual offence, the applicant must produce verification that they have successfully completed a sex offender treatment program;
7.  complete a pre-admission medical and have the forms signed by a qualified medical professional (including a TB skin test or chest x-ray result from tests completed within the last year);
8.  be in stable health;
9.  have a valid medical care card.

We strongly recommended that –

10.  the applicant participates in 4-6 sessions with counsellor, therapist, psychologist, psychiatrist or referral worker prior to treatment, plus follow-up sessions;
11.  the applicant has community-based support group experience - this helps to make best use of the group experiences in the trauma program;
12.  In order for clients to get the most out of their time at Tsow-Tun Le Lum, we encourage their participation in the cultural and traditional ceremonies and practices that are incorporated within our programs.

# INFORMATION for APPLICANTS

## MEDICAL

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- All medications MUST be blister packed and labelled by a pharmacist, or
- Prior to your intake date, have your physician FAX your prescriptions to:  
Central Drugs in Lantzville at (250) 390-4425.
- Please request enough medication for the duration of your program.
- Are you physically well enough to attend a 5-week program (8 hours a day, or longer)?

## TRAVEL CHECKLIST

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- All personal banking, bill payments, childcare, rent are taken care of
- Bring your valid medical care card
- Proper photo identification (requirement for flights and buses)
- Spending money or comfort monies arranged
- Travel arrangements including return fare (taxi, hotel, etc.)
- Blister packed medications
- Epi-pen if needed
- White soled/non-marking soled runners
- Slippers
- Men – large towel, sweat shorts, and t-shirt
- Women – large towel for sweats (flannelette gowns provided)
- Swimsuit
- Bath towels, hand towel, and facecloth
- Toiletries (shampoo, toothpaste, soap, razors, feminine needs, etc.)
- Writing paper, envelopes, stamps
- Arts and crafts projects, if on hand
- Musical instruments are allowed
- Smokers – bring enough cigarettes for duration of program
- No outside appointments scheduled or required
- Reading glasses
- Hearing aids and extra batteries

### IMPORTANT NOTE:

We are a  
SCENT-FREE  
building.  
Please do not bring  
scented products to  
Tsow-Tun Le Lum.

These include:  
shampoo, conditioner,  
other hair products,  
bodywash, soap,  
perfume, cologne,  
shaving lotion, body  
sprays, deodorant,  
lotions, powders, etc.

*Scented products can  
cause severe allergy  
reactions. Please respect  
the need for Fragrance-  
Free products.*

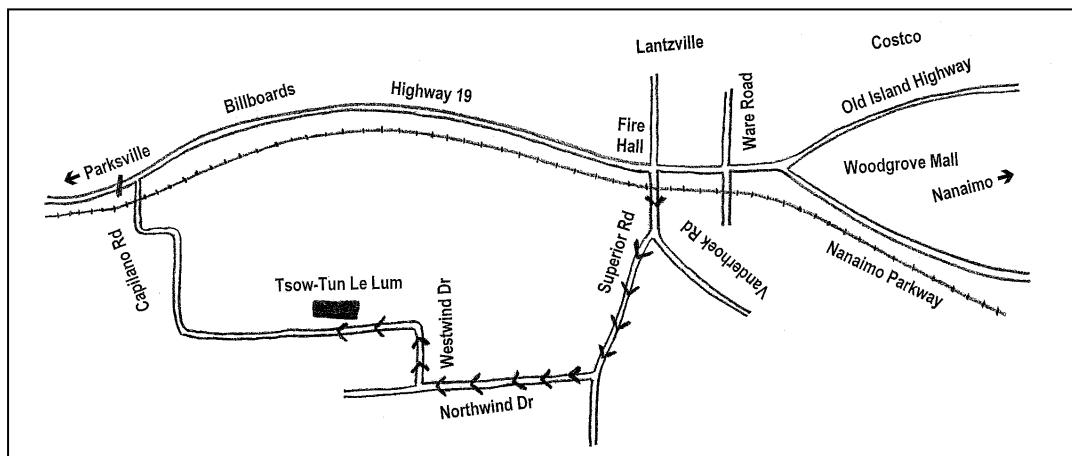
When you arrive at Tsow-Tun Le Lum:

- You can call home to let your family know you have arrived safely.
- Your referral worker will be notified if you have NOT arrived safely.
- During program there is limited opportunity to call your referral worker during business hours.



# LOCATION

Tsow-Tun Le Lum Helping House is located approximately 10 kilometres north of Nanaimo on Capilano Road on the Nanoose Band Reserve Land (Vancouver Island, BC). Travelling north on the Island Highway from Nanaimo, turn left at the Superior Road lights, then turn right on Northwind Drive, then turn right on Westwind Drive, and then turn left on Capilano Road.



Tsow-Tun Le Lum Phone Number: 250-390-3123

# TRANSPORTATION

Please be advised that:

- you are responsible for your own transportation to and from Tsow-Tun Le Lum.
- Tsow-Tun Le Lum will **not** cover transportation costs.

**Transportation Services** (the following companies accept taxi vouchers)

*(Prices updated March 6, 2020)*

AC Taxi	(250) 753-1231	<u>Base Rate to/from TTLL</u>	
		Nanaimo Airport or Duke Point Ferry	\$ 69.20
		Departure Bay Ferry	\$ 40.50
Yellow Cab	(250) 751-1111	<u>Base Rate to/from TTLL</u>	
		Nanaimo Airport or Duke Point Ferry	\$ 67.00
		Departure Bay Ferry to Tsow-Tun Le Lum	\$ 38.00
Nanaimo Airporter	(250) 758-2133	<u>Base Rate</u>	
		from Airport to Tsow-Tun Le Lum	\$ 44.00
		from Harbour Air to Tsow-Tun Le Lum	\$ 30.00



# SECTION TWO

## PRE-ADMISSION MEDICAL EVALUATION

### NOTES to PHYSICIAN

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*Tsow-Tun Le Lum has no medical personnel on site.*

- 1) The patient must not require any acute medical care at the time of admission.
- 2) All communicable diseases should be in remission and properly medicated.
- 3) The patient must be able to participate in a residential program of intense group and one-to-one counselling activities.
- 4) Tsow-Tun Le Lum's prescription protocol requires all prescriptions be blister packed prior to and during treatment. Please ensure the patient has prescribed medication for the duration of their program – up to five (5) weeks of prescriptions in blister packs.
- 5) If the patient is on **opioid** or **narcotic** prescriptions, please ensure to **FAX** five (5) weeks of their prescription to the Pharmacy below; and **MAIL** the original duplicate or triplicate prescription to the Pharmacy. *If you do not mail the original, the patient will not receive refills of narcotic or opioid prescriptions while in treatment.*
- 6) Prescriptions can be faxed / mailed to:  
Central Drugs Pharmacy  
7186 Lantzville Road  
Lantzville, BC V0R 2H0  
FAX: (250) 390-4425    PHONE: (250) 390-4423
- 7) Pregnant patients/ applicants will be accepted prior to the 3<sup>rd</sup> trimester.
- 8) Please return this medical evaluation to the patient to be included with their application.



# PRE-ADMISSION MEDICAL EVALUATION

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Patient Name:	Date of Birth:
Medical Number:	Status Number:

Physician Name:	
Full Address or Office Stamp:	
Physician Signature:	Date:

## INFORMED CONSENT: Must be Completed with the Patient

I, (patient name) \_\_\_\_\_,  
give permission to (Physician name) \_\_\_\_\_,  
and to (Pharmacist name) \_\_\_\_\_,  
to release my medical information to Tsow-Tun Le Lum Helping House  
and to my Referring Counsellor (Name)\_\_\_\_\_.

I also consent to have Tsow-Tun Le Lum's staff and consulting Medical Professional(s),  
inquire or consult with my physician on my medical needs while I am in treatment.

Patient Signature:	Date:
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<b>Patient Assessment</b>	
Date of last alcohol / drug use (including medicinal/recreational marijuana or use of any products containing THC or CBD)	(dd/mm/yyyy)
Is patient compliant with their treatment plan / prescribed medications? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you reviewed the prescribed medications for this patient? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of prescribed medication review:
Allergies to MEDICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO Please Specify:	
Other Allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO Please Specify:	
Does the patient require an <b>Epi-Pen</b> or <b>Ana kit</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If the answer is yes, please ensure that the patient is prescribed an Epi-Pen/Ana kit.</i>
<b>Current Medical Diagnosis</b>	
Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO Stable & under control? <input type="checkbox"/> YES <input type="checkbox"/> NO Please explain details:	
History of seizures <input type="checkbox"/> YES <input type="checkbox"/> NO Please explain details:	
Heart Condition <input type="checkbox"/> YES <input type="checkbox"/> NO Please explain details:	
Other (Please specify)	
<b>General Health of the Patient</b>	
Please check (✓) any conditions that apply:	Details / Comments:
Arthritis	<input type="checkbox"/>
Asthma / Respiratory	<input type="checkbox"/>
Auto-Immune Condition (Specify type)	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/> Trimester:



Psychiatric Record		Please check (✓) any conditions that apply	
Does the patient have a psychiatric history?		<input type="checkbox"/>	<input type="checkbox"/> Past <input type="checkbox"/> Present
Psychiatric Family History? (parents / grandparents / siblings)		<input type="checkbox"/>	
Suicide attempts during previous 2 years?		<input type="checkbox"/>	Dates:
Was patient hospitalized due to suicide attempts?		<input type="checkbox"/>	Dates:
Was patient hospitalized due to mental illness?		<input type="checkbox"/>	Dates:
Diagnosed Mental Health Illness? <input type="checkbox"/> Specify			
Anxiety Disorder <input type="checkbox"/>		Clinical Depression <input type="checkbox"/>	
Bi-polar Disorder <input type="checkbox"/>		Post-traumatic Stress Disorder <input type="checkbox"/>	
Sleep Disorder <input type="checkbox"/>		Schizophrenia <input type="checkbox"/>	
Eating Disorder <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/>		Dissociative Identity Disorder <input type="checkbox"/>	
Other (specify) <input type="checkbox"/>		Self Harming Behaviour <input type="checkbox"/>	
LIST OF CURRENT MEDICATIONS			
Over the counter medications must be included on this list.			
Medication:	Used to Treat:	Prescribed Dosage:	Taking Since:
Is this patient prescribed medicinal cannabis or any product containing THC or CBD? If yes, please include in this list.			
OTHER Medical Information you feel it is important for us to know about.			

# SECTION THREE

## APPLICATION PACKAGE

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### REFERRAL WORKER INFORMATION

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Name of Referral Worker \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Referral Agency \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

PLEASE CHOOSE ONE ONLY:

#### Kwunatsustul Trauma Programs

*DO NOT submit application until the applicant has minimum six (6) months sobriety. This sobriety requirement **includes 6 months free of alcohol, mind-altering drugs, methadone, suboxone, medicinal or recreational marijuana, and all cannabis products containing THC or CBD.***

Five Week Trauma Program

2-week Elders & Colleagues Trauma Program

#### Shorter Kwunatsustul Programs

*DO NOT submit application until the applicant has minimum one (1) month sobriety. This sobriety requirement **includes 1 month free of alcohol, mind-altering drugs, methadone, suboxone, medicinal or recreational marijuana, and all cannabis products containing THC or CBD.***

Honouring Grief

Other Short Trauma Program \_\_\_\_\_

### APPLICANT NAME

SURNAME \_\_\_\_\_ GIVEN NAME \_\_\_\_\_



# PERSONAL INFORMATION

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**SURNAME** (legal name) \_\_\_\_\_ **GIVEN NAME(S)** \_\_\_\_\_

Known as (most often called) \_\_\_\_\_

**HEALTH INSURANCE NUMBER** \_\_\_\_\_

**BIRTH DATE (Day/Month/Year)** \_\_\_\_\_

**GENDER:**  Male  Female  Identifies as \_\_\_\_\_

**BAND NAME** \_\_\_\_\_ **FULL STATUS NUMBER** \_\_\_\_\_

Status Indian:  Yes  No  Métis  Inuit

Residential School Survivor:  Yes  No

Intergenerational Survivor:  Yes  No Adopted / Foster Care:  Yes  No

Family substance abuse history? (Parents / Grandparents / Siblings)  Yes  No

Street (Permanent Address) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ **Email** \_\_\_\_\_

Usual Occupation \_\_\_\_\_

## Marital Status

\_\_\_ Single                      \_\_\_ Married                      \_\_\_ Common-Law  
\_\_\_ Separated                      \_\_\_ Divorced                      \_\_\_ Widowed

## Highest level of Education

\_\_\_ No Education                      \_\_\_ Primary School                      \_\_\_ Junior High                      \_\_\_ Secondary  
\_\_\_ Some Primary                      \_\_\_ Some Secondary                      \_\_\_ Trade School                      \_\_\_ University  
\_\_\_ Adult Education                      \_\_\_ Community College

## Legal Status

\_\_\_ Not Applicable                      \_\_\_ Parole                      \_\_\_ Probation  
\_\_\_ Temporary Absence                      \_\_\_\_\_ Other

## Family Type

\_\_\_ Living Alone                      \_\_\_ Living with Spouse  
\_\_\_ Living with Parents                      \_\_\_ Single Parent  
\_\_\_ Living with Friends                      \_\_\_ with Spouse & Children  
\_\_\_ with Extended Family                      \_\_\_ Other                      \_\_\_ Homeless

**Next of Kin:** \_\_\_\_\_ **Relationship to applicant:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Phone #s:** \_\_\_\_\_



# APPLICANT'S HISTORY

## Chemical Dependency

### 1. History of substance use

DRUG CLASS	Is Use a current problem? Please ✓	Date of last use
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Crack Cocaine / Cocaine Powder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Crystal Meth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ecstasy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fentanyl	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hallucinogens	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Inhalants	<input type="checkbox"/> Yes <input type="checkbox"/> No	
LSD	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Marijuana/Cannabis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicinal Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CBD Oil	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cannabis Edibles	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Methamphetamine/Speed	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mushrooms	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Narcotics / Opiates (ex. Morphine, Oxycodone, Codeine, Percocet etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	
OAT (ex. Methadone / Suboxone)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PCP	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Prescription Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleeping Pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tranquilizers/Anti-Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (describe)		

### 2. Does the applicant use the following as a coping mechanism?

	Is Use a current problem? Please ✓	How Often?
Bingo	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Casino	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationships	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Shopping	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Work	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Screens (cell phone, TV, tablet, computer, gaming)	<input type="checkbox"/> Yes <input type="checkbox"/> No	



3. Has the applicant attended a treatment program in the past?  
 Year \_\_\_\_\_ Number of times \_\_\_\_\_ Location \_\_\_\_\_  
 Year \_\_\_\_\_ Number of times \_\_\_\_\_ Location \_\_\_\_\_  
 Year \_\_\_\_\_ Number of times \_\_\_\_\_ Location \_\_\_\_\_
4. List significant nutritional issues (i.e. diabetes, allergies, etc). \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## LEGAL

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1. Does the applicant have a criminal record? Yes No  
 If yes, date of charge: \_\_\_\_\_  
 What were the charges? \_\_\_\_\_
2. Has the applicant been violent or abusive with their partner or children? Yes No  
 If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_
3. Has the applicant been charged with a violent offence? Yes No  
***If yes, please request "Violent Offender Protocol" from Tsow-Tun Le Lum.***  
 If yes, date of charge: \_\_\_\_\_  
 What were the charges? \_\_\_\_\_
4. Has the applicant been charged with a sexual offence? Yes No  
***If yes, please request "Sexual Offender Protocol" from Tsow-Tun Le Lum.***  
 Was the victim a minor? Yes No  
 Is the applicant a treated sexual offender? Yes No  
***Tsow-Tun Le Lum only accepts treated sex offenders.***
5. Are there any: Outstanding warrants  Charges  Court cases
6. Is applicant presently on: Parole  Probation  Incarcerated   
***Please attach a copy of the order.***
7. Are there any outstanding child custody issues? Yes No



# COUNSELLOR'S PERSPECTIVE

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1. When was the last time the applicant used alcohol or drugs (including cannabis products or marijuana)? \_\_\_\_\_
2. What do you need us to know about the applicant? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Has the applicant ever disclosed harming anyone in a sexually abusive manner or displayed sexually inappropriate behaviour? Yes No  
Explain: \_\_\_\_\_

## GROUP READINESS

4. Is the applicant willing to share about their past in a group setting? \_\_\_\_\_
5. How is the applicant preparing for a trauma program? \_\_\_\_\_  
\_\_\_\_\_
6. Is the applicant attending support groups on a regular basis? Yes No  
How often? \_\_\_\_\_

## REFERRAL

7. Has the applicant been seeing you on a regular basis? Yes No  
If yes, how many times? \_\_\_\_\_
8. Will you, as the referral person, be doing follow-up with the applicant after they have completed their program? Yes No

# SPECIAL NEEDS

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1. Does the applicant have any physical limitations that would prevent them from doing: daily chores, recreation, and cultural activities? Explain below in #7  Yes  No
2. Does the applicant require a wheelchair accessible room/bathroom?  Yes  No
3. Does the applicant have any special needs that Tsow-Tun Le Lum Staff need to be aware of while they are in treatment? Explain below in #7  Yes  No
4. Does the applicant require a hearing aid? (If yes, in order for the applicant to participate fully in group sessions, ensure they have their hearing aid and batteries).  Yes  No
5. Does the applicant require glasses?  Yes  No
6. Does the applicant require dental work?  Yes  No
7. If you answered "YES" to any of the above questions, please outline.







# CONSENT FOR TREATMENT

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I, (name of applicant) \_\_\_\_\_, understand that my participation in the Kwunatsustul Program at Tsow-Tun Le Lum Helping House requires that I am – (please check boxes)

- aware that Tsow-Tun Le Lum Kwunatsustul Program is a continuous program which begins upon my arrival and ends following the completion ceremony,
- aware that Tsow-Tun Le Lum will maintain my confidential client records in accordance with the Privacy Act.
- aware that Tsow-Tun Le Lum will contact the persons as I have consented to in the 'Consent for Release of Information' form.
- aware that Tsow-Tun Le Lum has the right to conduct random drug testing / searches.

I understand that for clients and staff to work effectively, the program includes a schedule of events and activities which require my **full participation**–

- Counselling assessments and care plans
- Arts & crafts, recreation activities (yoga, swimming, walking, etc), ceremonies
- Group therapy sessions/art therapy/lifeskills training/sessions with Elder/assignments
- Alcoholic Anonymous/Narcotics Anonymous/Co-Dependency meetings
- I understand that if I am unwilling to participate fully in any of the above activities, I may be asked to leave.
  
- I understand that there are on-going programs at Tsow-Tun Le Lum, where applicants have been referred from various community resources (i.e. NNADAP, Friendship Centres, Social Workers, Doctors, Detox, Employers, Alcohol and Drug Counsellors, and Parole.)
  
- I am aware that whenever people gather, such as at home communities, social and spiritual functions, family and treatment programs, etc., there may be identified and unidentified violent and sexual offenders present. This is also true of Tsow-Tun Le Lum Helping House.
  
- I understand successful outcomes are best achieved when followed up with support in community.
  
- I understand the explanation of the above points, and therefore consent to undergo treatment at Tsow-Tun Le Lum Helping House.
  
- I understand I can withdraw or amend my consent to the release/request of information at any time. I also understand that if I revoke this authorization, it will not affect any actions taken before the revocation was received.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Referral Worker's Signature \_\_\_\_\_



# CONSENT FOR RELEASE OF INFORMATION

I, (applicant's name) \_\_\_\_\_ hereby give my permission for staff at Tsow-Tun Le Lum to contact those persons identified below for the release of pre-treatment information, attendance verification, disclosure of progress during treatment, and aftercare planning and final discharge report if requested.

I understand that no other information will be released to any other persons without my written consent unless these persons have a court order or are concerned with my medical treatment in an emergency. I also understand that if I revoke this authorization, it will not affect any actions taken before the revocation was received.

ALL INFORMATION IS CONFIDENTIAL in accordance with relevant statutes.

Name:	Contact information:	Type of information that may be released to this person:
<b>REFERRAL WORKER</b>  Organization: _____	Phone: _____ Fax: _____ Email: _____	<input type="checkbox"/> Pre-Treatment Information <input type="checkbox"/> Attendance Verification <input type="checkbox"/> Progress during Treatment <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Final Discharge Report
<b>ALTERNATE REFERRAL CONTACT</b>  Organization: _____	Phone: _____ Fax: _____ Email: _____	<input type="checkbox"/> Pre-Treatment Information <input type="checkbox"/> Attendance Verification <input type="checkbox"/> Progress during Treatment <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Final Discharge Report
<b>INDIVIDUAL #3</b>  Organization: _____	Phone: _____ Fax: _____ Email: _____	<input type="checkbox"/> Pre-Treatment Information <input type="checkbox"/> Attendance Verification <input type="checkbox"/> Progress during Treatment <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Final Discharge Report
<b>INDIVIDUAL #4</b>  Organization: _____	Phone: _____ Fax: _____ Email: _____	<input type="checkbox"/> Pre-Treatment Information <input type="checkbox"/> Attendance Verification <input type="checkbox"/> Progress during Treatment <input type="checkbox"/> Aftercare Planning <input type="checkbox"/> Final Discharge Report

Applicant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(may be referring person or assessor)

*NOTE: This form is applicable for two (2) years after signed and dated. The applicant may change or revoke this release at any time by giving notice in writing to Tsow-Tun Le Lum.*

