



RECOVERY ROAD

APPLICATION FOR ADMISSION

Streets Alive

323-4 Street South
Lethbridge, AB
T1J 1Z9
Ph: 403-320-1159
Fax: 403-320-1060

Personal Information:

Name: _____
(First, Middle, Last)

Date: _____

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

Age: _____

Health #: _____ Treaty # _____ Prov: _____

Current Address: _____

Phone #: _____ Alternate Phone #: _____

Select Applicable Program:

GENESIS: (Women's Life Recovery Program) _____

EXODUS: (Men's Life Recovery Program) _____

Referral Agent Information:

Name: _____

Agency: _____

Location: _____

Phone #: _____

Prior Recovery/Treatment Experience:

Agency/Centre: _____

Date: _____

Agency/Centre: _____

Date: _____

Agency/Centre: _____

Date: _____



Substance Use History:

Primary Substance of Concern: _____ Since (Duration of use): _____
Additional Substance of Concern: _____ Since (Duration of use): _____
Additional Substance of Concern: _____ Since (Duration of use): _____
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Previous Substances of Concern: _____
Additional Comments: _____

Medical History:

Current Physical Situation including concerns that may not impact your daily ability to participate in programming.
(EX. Physical injury, Disease, Vision, Hearing, Mobility Issues, Learning Disability, etc.)

Condition: _____ Since: _____ Requires: _____
Impacts you how?

Condition: _____ Since: _____ Requires: _____
Impacts you how?

Condition: _____ Since: _____ Requires: _____
Impacts you how?

Highest Grade or level of education: _____

Any concerns with reading or writing? YES _____ NO _____ Comments: _____

Have you tested positive for HIV or Hepatitis C? YES _____ NO _____ Comments: _____

Allergies (Medication, Nature, Other): _____

Current Doctor: _____ Phone Number: _____

Any additional Comments or Concerns: _____



MEDICATIONS:

Name: _____ Purpose: _____ Dose/Frequency: _____
Name: _____ Purpose: _____ Dose/Frequency: _____
Name: _____ Purpose: _____ Dose/Frequency: _____
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****Some medications are not permitted in this program**Opioid Replacement Therapy (Suboxone) is permitted but a plan for reduction MUST be in place and agreed upon prior to acceptance into Recovery Road.**

Mental Health Concerns:

Please list officially diagnosed conditions as well as those of possible concern.

Condition: _____ Official Diagnosis: YES _____ NO _____ Date: _____
Condition: _____ Official Diagnosis: YES _____ NO _____ Date: _____
Condition: _____ Official Diagnosis: YES _____ NO _____ Date: _____

Any history of auditory or visual hallucinations? YES _____ NO _____

If yes, please explain: _____

Have you ever had thoughts of, or made attempts of self harm/suicide? YES _____ NO _____
Please explain:

Is this still a concern for you currently? _____

Have you recently experienced a loss of friends or family? If so, who and when?: _____

Legal History and Concerns:

Do you have any pending legal charges that need to be addressed? If so, for what?: _____

When? _____ Where: _____

Are you currently on probation or parole? YES _____ NO _____

Reason: _____

Name of Probation/Parole Officer: _____ Phone #: _____



Conviction History:

Charge: _____ Date: _____ Result: _____

Charge: _____ Date: _____ Result: _____

Charge: _____ Date: _____ Result: _____

Charge: _____ Date: _____ Result: _____

Additional Information: _____

Financial Information:

Do you currently have any form of financial support? YES _____ NO _____

If so, what is your source? _____ Agency contact: _____ Phone #: _____

If not, what is your plan? _____

Supports:

Who is supportive of your pursuit of change? _____

What is your marital Status? _____

Do you have children? YES _____ NO _____ How many: _____ Age(s): _____

Do you need or desire to work towards reconciliation of family relationships? YES _____ NO _____

If so, with who? _____

- **Any misrepresentation in the application can lead to removal from the program if accepted.**
- **Submitting application does not guarantee a bed date.**



Please Review, initial, and sign below:

I have reviewed the Recovery Road Program Outline Initial: _____

I understand that this is a faith-based program Initial: _____

I consent to full participation in this program Initial: _____

I have reviewed the rules and agree to comply Initial: _____

I consent to release of information pertinent to all aspects of my recovery plan Initial: _____

I _____, agree that all information provided in this application is accurate and correct. By signing this application, I am stating that I clearly understand the rules, requirements, and expectations of my participation in the Recovery Road Program. I am aware that I can have my stay terminated for violation of policy at any time.

Signature of Applicant: _____

Print Name: _____

Date: _____

FOR RECOVERY ROAD OFFICE USE ONLY:

Date of Phone Interview: _____

Staff: _____

Date of Admission: _____