



**Chief Red Bear**  
CHILDREN'S LODGE

## ADMISSIONS PACKAGE – SACRED WOLF LODGE

### PERSONAL INFORMATION

Photo of Individual

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Health # \_\_\_\_\_

Band/Treaty # \_\_\_\_\_

Relationship status: \_\_\_\_\_

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

Religion: \_\_\_\_\_

Language at Home: \_\_\_\_\_ First Language: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Physical Description of any scars, tattoos, piercings, etc.:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLACEMENT HISTORY**

List all placements, including those with relatives, beginning with current placements and working backwards (Use additional page if necessary):

Placement: \_\_\_\_\_ Date of Intake: \_\_\_\_\_

Date of discharge: \_\_\_\_\_

Reason for move:

\_\_\_\_\_

Placement: \_\_\_\_\_ Date of Intake: \_\_\_\_\_

Date of discharge: \_\_\_\_\_

Reason for move:

\_\_\_\_\_

What are your goals while residing at the Sacred Wolf Lodge?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the challenges would like to work on while residing at the Sacred Wolf Lodge?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the expected period residing at Sacred Wolf Lodge?

\_\_\_\_\_  
\_\_\_\_\_

List the discharge resources that will be explored:

\_\_\_\_\_  
\_\_\_\_\_

Are there any special conditions with respect to the placement? (Please Circle) **Yes** or **No**  
(i.e., one-on-one, 24-hour supervision, safety concerns, supervised visits, no access, no contact, etc.). If **yes**, what are they?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Saskatchewan Health Insurance Number (SHIN): \_\_\_\_\_

Copy of SHIN card attached? (Please circle) **Yes** or **No**

Notes: If **No** Please attach copy of SHIN prior to admission date.

Are you currently on **Medication**? (Please Circle) **Yes** or **No**  
If **yes**, please note the description of medication/Physician's name below.  
**Notes: All medications follow under the medication administration process/agreement while residing at Sacred Wolf Lodge. All current medication information is to be submitted prior to admission.**

Name of medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Name of Physician prescribed medication: \_\_\_\_\_  
Administration times/instructions: \_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Name of Physician prescribed medication: \_\_\_\_\_  
Administration times/instructions: \_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Name of Physician prescribed medication: \_\_\_\_\_  
Administration times/instructions: \_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Name of Physician prescribed medication: \_\_\_\_\_  
Administration times/instructions: \_\_\_\_\_  
\_\_\_\_\_

Has a yearly **physical checkup** been completed? (Please Circle) **Yes** or **No**  
If **yes** please fill out below.

Name of Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date of last/recent visit: \_\_\_\_\_

Is there any difficulty **hearing**? (Please Circle) **Yes** or **No**  
If **yes**, please note the difficulties: \_\_\_\_\_

Has a physician been visited for hearing? (Please Circle) **Yes** or **No**. If Yes, please fill out below.

Name of Physician: \_\_\_\_\_

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

Date of last/recent visit: \_\_\_\_\_

Are there any difficulties with **vision/eyes**? (Please Circle) **Yes** or **No**  
Does the Individual wear glasses/contacts? (Please Circle) **Yes** or **No**  
Does the Individual have difficulty seeing? (Please Circle) **Yes** or **No**  
If **yes**, please note the difficulties: \_\_\_\_\_

Has a physician been visited for vision/eyes? (Please Circle) **Yes** or **No**. If Yes, please fill out below.

Name of Optometrist: \_\_\_\_\_

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

Date of last/recent examination: \_\_\_\_\_

Is there any difficulty with **mouth/teeth area**? (Please Circle) **Yes** or **No**  
If **yes**, please note the difficulties: \_\_\_\_\_

Has a dentist been visited? (Please Circle) **Yes** or **No**. If Yes, please fill out below.

Name of Physician: \_\_\_\_\_

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

Date of last/recent visit: \_\_\_\_\_

Does the Individual have any **allergies/medication** alert conditions? (Please Circle) **Yes** or **No**  
If **yes**, please note any allergies or reactions to food/medication/products, etc:  
\_\_\_\_\_

Has a physician been visited to confirm allergies? (Please Circle) **Yes** or **No**. If Yes, please fill out below.

Name of Physician: \_\_\_\_\_

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

Date of last/recent visit: \_\_\_\_\_

Is there any **physical concerns** occurring at the present (i.e., hypertension, headaches, dizziness, etc.)? (Please Circle) **Yes** or **No**

If **yes**, please note the difficulties: \_\_\_\_\_

Is there any trouble **sleeping at night**? (Please Circle) **Yes** or **No**

If **yes**, how long has this been a problem? \_\_\_\_\_

Has a physician been visited for concerns as listed above? (Please Circle) **Yes** or **No**. If Yes, please fill out below.

Name of Physician: \_\_\_\_\_

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

Date of last/recent visit: \_\_\_\_\_

Is there any suspected or confirmed **developmental challenges** (i.e., Fetal alcohol exposure, ADHD, etc.)? (Please Circle) **Yes** or **No**

If **yes**, please note the difficulties: \_\_\_\_\_

Has a physician been visited for concerns or assessment in process? (Please Circle) **Yes** or **No**.

If Yes, please fill out below.

Name of Physician: \_\_\_\_\_

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

Date of last/recent visit: \_\_\_\_\_

**FAMILY RELATIONS/HISTORY**

Spouse's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Describe the individual's relationship with spouse: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mother's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Describe the individual's relationship with mother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Father's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Describe the individual's relationship with father: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are your parents together/separated/divorced/widowed, etc.? \_\_\_\_\_  
Please describes what is you parent's relationship like? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have siblings (brother(s)/sister(s))? (Please Circle) **Yes** or **No**.  
If yes, please list names of siblings below.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Briefly describe the Individual's relationship with other caregivers (if applicable):

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**CONTACTS/SUPPORTS**

Please identify the family member(s) who are **appropriate** to participate in:  
Please list the name(s) of any individuals listed as support person(s):

Name: \_\_\_\_\_ **Male or Female** (Please circle)  
Phone Number: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Family Circle of Care Meetings: (Please Circle) **Yes or No**  
Family visits: (Please Circle) **Yes or No**  
Family telephone calls: (Please Circle) **Yes or No**

Name: \_\_\_\_\_ **Male or Female** (Please circle)  
Phone Number: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Family Circle of Care Meetings: (Please Circle) **Yes or No**  
Family visits: (Please Circle) **Yes or No**  
Family telephone calls: (Please Circle) **Yes or No**

Name: \_\_\_\_\_ **Male or Female** (Please circle)  
Phone Number: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Family Circle of Care Meetings: (Please Circle) **Yes or No**  
Family visits: (Please Circle) **Yes or No**  
Family telephone calls: (Please Circle) **Yes or No**

**NON-CONTACTS/RESTRICTED CONTACTS**

Please list the name(s) of any individuals that the individual is **NOT** to have contact with:

Is there a history or recent occurrence(s) of abuse to this Individual? (Please Circle) **Yes or No**  
If yes, which type(s) of abuse? Verbal      Physical      Sexual      Other: \_\_\_\_\_  
Name: \_\_\_\_\_ **Male or Female** (Please circle)  
Comments: \_\_\_\_\_

Is there a history or recent occurrence(s) of abuse to this Individual? (Please Circle) **Yes or No**  
If yes, which type(s) of abuse? Verbal      Physical      Sexual      Other: \_\_\_\_\_  
Name: \_\_\_\_\_ **Male or Female** (Please circle)  
Comments: \_\_\_\_\_

Is there a history or recent occurrence(s) of abuse to this Individual? (Please Circle) **Yes or No**  
If yes, which type(s) of abuse? Verbal      Physical      Sexual      Other: \_\_\_\_\_  
Name: \_\_\_\_\_ **Male or Female** (Please circle)  
Comments: \_\_\_\_\_



**DEVELOPMENTAL HISTORY**

Please rate the individual's development (compared to others of the same age) in the following areas:

**Challenging (improvement)**    **Medium (understanding level)**    **High (above average)**

Social: \_\_\_\_\_

Physical: \_\_\_\_\_

Language: \_\_\_\_\_

Intellectual: \_\_\_\_\_

Emotional: \_\_\_\_\_

For each type of development that you rated where needs improvement, please describe current areas of concern (be specific):

List any phobias you have (i.e., fear of the dark, fear of water, claustrophobia, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List your strengths:

\_\_\_\_\_  
\_\_\_\_\_

List any challenges or areas of improvement:

\_\_\_\_\_  
\_\_\_\_\_

List any challenges at home:

\_\_\_\_\_  
\_\_\_\_\_

List any experiencing problems/difficulties at school:

\_\_\_\_\_  
\_\_\_\_\_

Describe your friendships:

\_\_\_\_\_  
\_\_\_\_\_

Describe your hobbies and interests even if you have not been able to fulfill these interests:

\_\_\_\_\_  
\_\_\_\_\_

What forms of discipline/consequences are used in your home:

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If disciplined was to take place describe what would be consequences for misbehavior?

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Are there any comments or concerns you would like to list in relation to developmental history?

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**BEHAVIOUR OR CONCERN AND IMPACT ON THE INDIVIDUAL**

Briefly describe your ways of expressing the following emotions or behavior:

Anger:

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Happiness:

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Sadness:

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Anxiety:

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List your behaviors you would like to see improvement on:

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**EDUCATION**

Name of present school: \_\_\_\_\_ Year: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Last School Attended: \_\_\_\_\_ Year: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Is the cumulative file/Individual Educational Plan (IEP) and/or Report Card attached? **Yes** or **No**. If **No** please attach report card and if Individual Education plan completed please attach.  
Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your attitude/outlook towards school:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the Individual's academic progress:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please identify your current experiences below by rating the following contents:

**Yes**      **No**      **Unknown**

Difficulty with reading

Difficulty with mathematics

Difficulty with spelling

Difficulty with writing

List any awareness/insights you have that have an impact with behaviors and challenges in school:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all other areas known to the writer regarding the Individual's educational needs (If applicable):

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Does the Individual wear eyeglasses in the classroom? (Please Circle) **Yes** or **No**

Has the Individual had an Educational Assessment? (Please Circle) **Yes** or **No**

If **yes**, who completed the Educational Assessment and which date:

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How does the Individual spend his/her free time in school?

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Is the Individual involved in sports, leisure, etc.? (Please Circle) **Yes** or **No**

If **yes**, what are they?

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**SOLVENT / DRUG ABUSE HISTORY**

Do you smoke tobacco and/or vape? (Please Circle) **Yes** or **No**  
If **yes** is the Individual under the age of 18? (Please Circle) **Yes** or **No**. If **yes** Parent will need to sign consent forms & follow expectations underlined under smoking policy while residing at Sacred Wolf Lodge & develop plan with parent and youth under 18 to detach from smoking.

Is the Individual a known user of alcohol and/or drugs and/or solvents? (Please Circle) **Yes** or **No**

If **yes**, describe pattern of use, include age at which use started, frequency, extent, etc.:

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Whether the Individual is a user or not, describe the pattern of alcohol and drug use within his/her family:

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Substance/Drug Abuse Assessment attached, if applicable:

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**COMMUNITY**

How do you spend your free time?

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Describe your peers/support person and/or role models:

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What are your interests and hobbies?

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List your major strengths:

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List your major challenges:

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What are the major problems to be addressed while at Sacred Wolf Lodge (i.e.: self-harm behaviors, aggression, substance abuse, separation and loss, sexual victimization/perpetration, attachment issues, criminal behaviors, etc.)?

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What is the anticipated period of residing at Sacred Wolf Lodge?

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What is the discharge plan?

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Has the Individual been involved in any illegal activity? (Please Circle) **Yes** or **No**. If yes please describe below.

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Have the police become involved? (Please Circle) **Yes** or **No**.

If yes, list charges, court dates, and dispositions and attach relevant documentation (i.e.: undertaking, probation, community service orders, subpoena to witness, etc.):

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Individual worker's name and phone number (If applicable):

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Are there any special conditions with respect to residing at Sacred Wolf Lodge? (Please Circle) **Yes** or **No**

If yes, what are they?

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Has the individual been involved in previous counselling? (Please Circle) **Yes** or **No**

If **yes**, which counsellor, name, address, phone number and indicate last appointment:

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If **not**, is a referral being completed? (Please Circle) **Yes** or **No**



**GOALS & CONNECTION**

What is your personal goal in applying for programs that can help you?

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Describe what would be your best possible outcome?

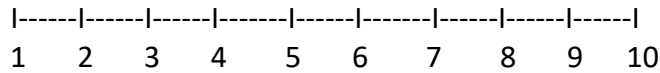
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If you had to rate your current situation. Where would you rate yourself?  
(1 meaning low you are feeling like things are not working out, 10 meaning everything is good there is nothing to work on)



What are the highest and most important things you need support for?

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Who loves you?

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Who wants to love you?

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Who deserves to love you?

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**ASSESSMENTS**

Notes: Please note any completed assessment must be attached and submitted prior to admission.

If any of the assessments have been completed, attach copies:

- 1. Assessment for drug and alcohol dependencies (i.e., SASSI).
- 1. Educational Assessment.
- 1. Psychological – Social Assessment
  - 1. Other:

**CONSENT**

I \_\_\_\_\_ understand the terms & conditions and responsibilities while residing at Scared Wolf Lodge. I \_\_\_\_\_ consent to access personal information in relation to supports & services provided within Chief Red Bear Children’s Lodge.

I \_\_\_\_\_ have provided the following information to be true and accurate to the best of my knowledge.

**Individual signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Notes: Parents/guardians please fill out consent for children & youth under the age of 18.

**OFFICE USE ONLY**

**Date of intake meeting:** \_\_\_\_\_

**Date of admission:** \_\_\_\_\_

**Referred by Whom:** \_\_\_\_\_

**Sacred Wolf Lodge Management:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Family’s/Individual’s Worker:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Chief Red Bear Children’s Lodge CEO:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**CRBCL Family Liaison Worker:** \_\_\_\_\_

**Date:** \_\_\_\_\_