The Crossing Point
BY VALIANT RECOVERY

The Crossing Point Integrative Addiction Services is a for profit organization offering services including Detox/Withdrawal Management, Residential Treatment, and Addiction Counselling (outpatient) for family members and former residential clients. All of our programs serve both adult men and women; in separate centers for Treatment and in a co-ed unit for Detox/Withdrawal Management.

The Crossing Point employs the brightest minds and best practices to empower clients and make them feel at home. It is important to our team that clients are treated with dignity and respect. Our professional staff are continually evolving through training and professional development and furthering their knowledge of addiction and the changing process.

Our therapists hold Masters Degrees in the field of Counselling. Many have extensive training and experience in other areas such mental health, eating disorders, relationship violence and trauma. They specialize in the area of addictions treatment.

We understand that everyone is different and has unique needs and as such we pride ourselves on our flexible approach. Our programs focus on wellness and we believe there are many factors that lead a person into addiction and that it is usually a combination of complex biological, psychological, sociological and spiritual influences. Embedded in addiction are all these facets of the human experience, which is why our approach can be quite effective and liberating for many people.

Residential Treatment Program is a 30 day intensive residential program that combines educational workshops with intensive group psychotherapy. The program helps clients to work through and begin to let go of issues related to grief, trauma and pain while offering them new tools to utilize once they leave treatment and to support their recovery. Here, clients are able to reinvent themselves and create a new script for the future.

Detox/Withdrawal Management Services provide a medically supervised, supported, safe environment. Here, patients receive medications to assist with the withdrawal symptoms when it is deemed necessary.

Addiction Counselling offers outpatient individual, couples and family counselling by Masters level therapists.

We work hard to ensure our clients are treated with respect and dignity and as the capable adults they are. We provide a structured environment in terms of daily routines. We strive to focus on relationships and processes, as we believe this provides a more effective learning and therapeutic context for treatment. We assist individuals in getting back on their feet and re-gaining control over their lives! This approach helps to guide our clients to a renewed sense of responsibility for themselves, their families and their community.

Check out our website for more information and details.

www.XRDSTC.net

Residential Treatment Program
Referral Package Overview

This referral package includes the following:

1. Information about our program.
2. An Application for Admission Form (3 pages).

KELOWNA, B.C.
PHONE: (250) 878-5806
TOLL FREE: 1 866 413-3667 info@xrdstc.net

3. A Client Check List
4. A Legal History Form to be completed by anyone with a criminal history.
5. A Pre-Admission Medical Status Form and Prescription Form to be completed by a physician.
6. A Payment Information Form and Human Resources Funding Form (complete *only* one depending on your funding source).
7. A Cardholder Charge Authorization Form to be completed for all credit card payments.
8. A Voluntary Consent to Release Information Form if there are individuals that you would like The Crossing Point to share information with.

→ Once you have completed the necessary forms, submit them to The Crossing Point (by fax or mail; the information is located at the top of this page).

→ Have your doctor complete the medical forms and then have them forwarded to us.

→ You must submit written confirmation of a negative TB test result (X ray or skin test within the last four months).

ONCE ALL YOUR INFORMATION IS RECEIVED, YOU WILL BE CONTACTED AND GIVEN AN ADMISSION DATE.

Self Pay Refund Policy: Refunds are Not made if the client leaves treatment. This is a common practice in the field of addiction treatment. How ever we will allow any unused funds to be used to wards a future treatment program for the same individual in the 12 months following their discharge date.

If you have any questions or need assistance at any time, please do not hesitate to contact the Admission staff. We look forward to your arrival.

Application for Admission

Please fill out this form with your client.

Today's Date: _____

Program(s) applied for: ☐ **Detox/Withdrawal Management** ☐ **Residential Treatment**

□ **Outpatient Counseling**

Referral Source Information:

Referral Source Name: _____

Position: _____ Agency: _____

Address: _____

Phone Number: (___) _____ _ Fax: (___) _____ _ E-mail:

Mandatory Follow –up:

An alcohol and drug counselor is required to be responsible for the discharge teleconference & follow up of this client's relapse prevention plan.

Name:_____ Organization:_____

Address:_____ Phone:_____

Email:_____ Fax:_____

Client Information:

Name: _____
First Middle Last

Prefer to be called:_____ Male ☐ Female ☐ Other ☐

Address: _ _____ Apt #
Street City Postal Code

Home Phone: _____ Mobile/Alternative: _____ Email (optional):_____

Is it ok to speak to another member of the client's household? ☐ Yes ☐ No

PHN# (Care Card): _____ Area of residence:_____ Date of Birth: _____ _ Age: _____ SIN: _____ _ Marital status:

Number of dependent children: _____ Education:

Employment Status: _____ **Emergency Contact Person:**

Name: _____ _ Relationship _____ _ Contact Number: (___) _____ _ Alternate: (___) _____ **Sign here to confirm emergency contact authorization**:_____

Please note: If a client is absent for more than 6 hours without our knowledge of their whereabouts, both your emergency contact and the RCMP will be notified. Also, due to licensing regulations a picture is required to be taken for all clients.

Funding Source for Treatment

□ Self Pay - Complete Payment Information Form – you are paying 100% of your fees (either yourself or through an employer/EAP/Union/or other non-government entity

Funding Source for Detox

□ Detox Services – Self Pay - Complete Payment Information Form – you are paying 100% of your fees

Treatment & Counselling History: (Please provide name of agency and dates)

Outpatient Counselling:_____

Day Treatment:_____

Residential Treatment: _____

What is the client doing now to achieve recovery?_____

Current Usage Information:

Abstinent at time of application? ☐ Yes ☐ No

If yes, client's clean/sober date: _____

Drug / Alcohol History:

Substance(s) of Choice	Duration of use (in years)	Frequency in last 30 days	Typical amount	Date of last use

Note: Clients must be capable of participating in programming upon admission and must not require a detox.

Aftercare:

Does the client have safe accommodations after treatment? ☐ Yes ☐ No

If yes, please explain: _____

In the event of an early discharge, will the client be returning to a safe environment? ☐ Yes ☐ No

Mental Health:

Is the client currently being treated for a mental health condition? Please specify:

Previous psychiatric hospitalizations? ☐ Yes ☐ No

If yes, when? Reason? _____

Any history of attempted suicide? ☐ Yes ☐ No

If yes, when? _____

Note: Please attach all relevant documentation to referral form (eg: assessments and/or screening tools, recent psychiatric discharge summaries, etc.)

I consent for The Crossing Point to release & exchange any pertinent information regarding my medical or mental health conditions with any medical or mental health personnel associated with me.

Client signature: _____ Date:_____

KELOWNA, B.C.
PHONE: (250) 878-5806
TOLL FREE: 1 866 413-3667
info@xrdstc.net

Client Check List - Residential Treatment Program

Thank you for applying to attend The Crossing Point Residential Treatment Program.

Please arrive at The Crossing Point on your scheduled intake day at your appointment time. If you cannot arrive at this time, please let us know well in advance so that we can make alternate arrangements. We ask that you have return transportation arranged prior to your arrival. Please arrange a return bus or airline ticket, or sufficient funds to purchase a ticket. If you require a taxi in Kelowna, the number is 250-762-2222. We do not provide coverage for transportation.

Bring the following items (**maximum luggage: 2 pieces**):

- Pen, binder with paper and journal
- $20.00 Laundry and Supply Fee (non-refundable)
- Personal toiletries (shampoo, soap, toothpaste, etc.)
- Bath towel, hand towel and face cloth
- Appropriate clothing for the season
- Running shoes and suitable clothing for recreation

Do not bring the following items:

- Items of value (jewelry, etc.)
- Any perishable food items
- Cameras or video cameras
- Laptops
- Large sums of money (a comfort allowance of $25.00/week should be sufficient)
- Nonprescription drugs
- Any substance related material including clothing or paraphernalia

Please note:

- All luggage is subject to inspection and a low grade heat treatment.
- Please ensure that you are free from all outside obligations (court dates, medical or other appointments, paying bills, etc.) for the entire period of your program.
- A telephone is available for local calls and long-distance calls. With Counsellors prior approval on weekends
- Visiting is arranged through your counselor. Due to confidentiality, visitors are not permitted in our centers. You may be eligible for an day pass on your third and fifth weekend.
- Cell phones *are not* permitted.
- Although there are not a specified number of clean days required, we recommend five to seven days abstinence. You must be capable of participating in programming upon admission and must not require a detox.
- Should you arrive under the influence of drugs or alcohol you may be charged additional fees to attend detox and/or be refused admission.
- In order for us to administer your medications, you must sign and follow the directions on the medication administration form included in this package.

Please feel free to contact our Admissions office at any time should you have questions regarding your scheduled admission date. We will be happy to assist you in any way that we can.

KELOWNA, B.C.
PHONE: (250) 878-5876
TOLL FREE: 1 866 413-3667
info@xrdstc.net

Legal History/Status Information

Does the client have any criminal history? □ Yes □ No
If yes, this form **must** be completed.

History of Aggression? □ Yes □ No
If yes, please explain: _____

Note: Clients may not attend court dates while at Crossroad. Clients are expected not to attend parole or probation appointments. If the client is on/or previously has been on probation, parole or currently incarcerated please complete the following.

□ Charges Pending ☐ Parole ☐ Probation ☐ Previous History

Upcoming court dates: _____

If yes, what were they most recently convicted of? _____

Sentence Length: _____ ☐ Conditional Sentence ☐ CSW ☐ Probation ☐ Incarceration

Has the client ever served Federal time? ☐ Yes ☐ No

If yes, have they reached warrant expiry? ☐ Yes ☐ No

Date	Charge	Sentence

Probation/Parole Officer Name: _____

Phone: _____Fax: _____

I consent for The Crossing Point to release and exchange any pertinent information regarding my legal history with any legal agencies associated with me.

Client signature: _____ Date: _____

116-7841 Hwy 97n KELOWNA, B.C. V4V 1E7
PHONE: (250) 878-5706
FAX: (250) 860-9685
TOLL FREE: 1 866 413-3667
info@xrdstc.net

Pre-Admission Medical Status Questionnaire

To Be Completed By a Physician

Patient Information:

First Name: _____Last Name: _____

Health Card #: _____Date of Birth: _____

Province: _____Patient Phone #: _____

Height: _____Weight: _____ BP: _____Pulse: _____

Date of last Chest X-ray or Mantoux test for Tuberculosis & results: _____
(A TB test result less than 4 months old is required to qualify for admission)

Drug/Food Allergies: _____

Medication:
Please check all categories representing types of prescription medication that are currently being used:

□ Anti-depressants ☐ Anti-anxiety ☐ Anti-psychotic ☐ Pain medication

□ Other (specify): _____

List the name and dosage of any medication the patient is currently taking and how long they have been taking each medication: _____

Methadone:

Length on methadone program: _____Current dose: _____ml.

Length of time on current dose: _____

Prescribing methadone Doctor's name: _____

Phone number: (___) _____

Medical History:
Current health/dental symptoms/conditions/diagnosis: _____

_____

Has patient suffered seizures in the past year: □ Yes □ No

If yes, were these seizures withdrawal related: □ Yes □ No

If not withdrawal related, do they have a seizure disorder: □ Yes □ No

If yes, please describe: _____

This patient is medically and physically capable of participating in an intensive residential treatment program for substance abuse.

Doctor's Name Date

Phone Number Fax Number

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Prescription Form

To Be Completed By a Physician

116-7841 Hwy97n KELOWNA, B.C. V4V 1E7
PHONE: (250) 878-5806
FAX: (250) 860-9685
TOLL FREE: 1 866 413-3667 info@xrdstc.net

Dear Doctor:

In order to facilitate admission to our program as quickly as possible, we request that you provide written orders for all required medications. Please write out all orders for the duration your patient will be attending. The Crossing Point requires participants to bring originals of all triplicate prescriptions with them for their admission date. If the patient may need any over-the-counter medications during their stay, please also provide a written order for them. Please be advised the program is 42 days in length.

Date:

Patient Name:

PHN # :

DOB:

Drug Allergies: _____

℞:

Medication	Instructions for Use	Days Supply/ Quantity

Required over-the-counter medications:

Physician's Signature: _____

Physician's Name (please print): _____

License #: _____

Telephone Number: (___) _____

All medications must comply with our medication administration policies. Clients can not bring their own medications for staff to administer. Please contact our office at the above number if you have any questions.

123 FRANKLYN RD., KELOWNA, B.C. V1X 6A9
PHONE: (250) 860-4001
FAX: (250) 860-2605
TOLL FREE: 1 866 860-4001
info@xrdstc.net

MEDICATION ADMINISTRATION AND MEDICAL NEEDS WHILE IN TREATMENT

The Crossing Point' Residential Treatment Program is not a medical center and we do not employ medical professionals (doctors or nurses). You must ensure that you are medically stable enough to be in a center that does not have a physician on site (a walk-in clinic is available nearby for basic medical needs).

Medication administration times occur four times a day - morning, noon, supper and evening. If you need medication administered outside of these times, the prescription must clearly state this.

- ☐ Bring a written prescription of your medications (form included in package) and we will assist you in faxing it to our pharmacy when you arrive (you are responsible for making any arrangements regarding costs) ***or***
- ☐ Fax your prescription to the pharmacy (we use **Paragon Pharmacy**: tel: (250) 868-9654) prior to your arrival and request that it be delivered to The Crossing Point Treatment Centre on the day you arrive.
- ☐ Bring these instructions to your pharmacist and have your medications blister-packed as described below and then bring them with you on your admission date. (This is the best option if you want to ensure that there are no delays in receiving your medications after arrival).

Any medication that you will require during your stay ***must be blister-packed in the following manner*** in order for them to be administered to you:

☐One medication card per medication, per time(s) to be given. For example, if you take Naproxen 250 mg. three times per day, we need three cards of Naproxen 250 mg for the length of your stay. We will file these three cards at the three different times you normally take this medication.

MEDICATION AGREEMENT: I understand that The Crossing Point can only administer medications that are prescribed by a physician and blister-packed in the above described manner. I agree to pay any cost incurred for my own medications.

Client signature **Date**

Payment Information

Self Payment - Treatment Application:

30 Day Treatment Program	$10,050.00
45 Day Treatment Program	$15,075.00
60 Day Treatment Program	$20,100.00
90 Day Treatment Program	$30,150.00

Self Payment - Detox/Withdrawal Management Application:

Self pay Detox/Withdrawal Management bed	$3,000.00	7 nights

Fees are payable upon admission by cash, certified cheque, money order.
Please contact The Crossing Point Treatment Centre reception for current availability.

☐ **Employer/Health Plan**:

Please select room desired from above list and the corresponding amount will be invoiced upon admission.

Date payment confirmed: _____

Confirmed by: _____
Please Print

Invoice to:

Contact Name:

Company Name/Agency:

Phone: (___) _____ Fax: (___) _____

Mailing Address:

Unit # Address City Prov. Postal Code

☐ **Mental Health and Addictions Services:**

Contact Name: _____Phone: (____) _____

Date of fee subsidy application: _____

Billing reference #: _____# of Days: _____

Self Pay Refund Policy: Refunds are Not made if the client leaves treatment. This is a common practice in the field of addiction treatment. How ever we will allow any unused funds to be used to wards a future treatment program for the same individual in the 12 months following their discharge date.

I have read and understand the The Crossing Point Treatment Centre Refund Policy:

Client signature **Date**

Payment Information continued

For all payments using credit card, print out this form, fill out and sign where noted.
Then fax this form to us. As soon as we receive the completed forms, we will process your payment.

CLIENT NAME: _____

I, _____***(full name as it appears on the credit card)*** authorize The Crossing Point Treatment Centre to charge my credit card for monies I owe The Crossing Point Treatment Centre for goods and / or services provided by The Crossing Point Treatment Centre.

Goods or Services	**Amount**	**Receipt #**
Non Refundable Deposit for Treatment	$500.00	
Balance of Treatment fees		
Non Refundable Deposit for Detox/Withdrawal Management	$700.00	
Detox/Withdrawal Management fees	$3,000.00	
Balance of Detox/Withdrawal Management fees		
DETOX EXTENSIONS I understand that I am responsible should the detox physician deem necessary for a longer stay in detox that each additional night will be charged at a rate of $350.00 per night. _____(initial)		
Balance of fees or extensions will be paid by (please specify): ☐ Cash □ Certified Cheque □ Money Order □ Bank Draft □ Debit Card □ This credit card □ Another credit card (please fax this page with new info)		
Total:		

PLEASE PRINT CLEARLY

VISA Ñ MasterCard Ñ American Express Ñ (Please tick next to appropriate card type)		
Card Number	CVV * 3 digit # on signature panel on back of card (immediately after card #)	Expiry Date
Name on Card:		
Cardholder Signature	Date	
Telephone		

Self Pay Refund Policy: Refunds are made only if the client leaves treatment in the first week (7 days). Refund is 50% of the full fee, payable only to the person/organization that paid the fee. Fees are non-refundable after the first week. Detox fees are non- refundable.

I have read and understand the The Crossing Point Treatment Centre Refund Policy.

Signature: _____

Please be advised that we do not share information provided to us with any third party. We take special care to make sure that all account and personal information is held in the strictest confidence.

Voluntary Consent for Release of Information

The Crossing Point maintains strict personal confidence rules. Without a written consent to release information, The Crossing Point will neither confirm nor deny that you are in our center. We do, however, need to speak to certain person(s) or agencies for the purpose of obtaining or providing information that will be helpful to your treatment plan (consider such people as lawyer, social worker, probation officer, counsellor and extended family members).

Name	Relationship to applicant	Phone number	Initials

I hereby give The Crossing Point Treatment Center personnel permission to release and obtain information from the above named individuals on my behalf in relation to my attendance, residence and participation while in The Crossing Point.

Client signature **Full name (please print)**

Date **Witness**

This consent is valid for 12 months from the date of signing.