HART Hub Hamilton

In partnership with Hamilton Urban Core CHC

HART HUB RESIDENTIAL TREATMENT AND RECOVERY PROGRAM

Application for Residential Treatment and Recovery Program

Hamilton Urban Core Community Health Centre (HUCCHC) HART Hub Hamilton

INSTRUCTIONS

1. Complete this form electronically or print it and complete it by hand.
2. Return the completed form or drop off at the main HART Hub site at 430 Cannon St E. Please note that email is not a secure platform, so confidentiality cannot be guaranteed when sending by email.
3. To book your intake assessment, please call 905-522-3233, ext. 501 or email mhathub@hucchc.com.

Program	HART Hub Residential Treatment and Recovery Program		
Program location	276 Aberdeen Ave, Hamilton, ON L8P 2R3		
Main Site and Mailing address	430 Cannon St, East Hamilton, ON L8L 2C8		
Phone	905-522-3233 ext. 501	**Fax**	Fax: 905-522-3433
Email	mhathub@hucchc.com	**Website**	Hamilton HART Hub website

PERSONAL INFORMATION

First Name		**Last Name**	
Full name at birth (if different)		**Chosen Name**	
Date of Birth		**Gender**	
Pronouns		**Ontario Health Card?**	Yes No
Health Card Number			
Home Address			
City		**Province**	
Postal Code		**Permanent address?**	Yes No
Phone Number		**OK to leave a message?**	Yes No

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Emergency Contact		**Relationship**	
Emergency Contact Phone			

REFERRAL INFORMATION

How were you referred to the HART Hub Residential Treatment and Recovery Program?	
Contact name at referring agency(ies)	

EMPLOYMENT & EDUCATION

Current employment status	
Education (highest level achieved)	

INCOME SOURCE

Disability Insurance	Employment	Employment Insurance (E.I.)
Family Support	Ontario Disability (ODSP)	Ontario Works (OW)
Other Insurance (excluding E.I.)	Retirement Income	Other

PREVIOUS TREATMENT INFORMATION

Have you had previous substance use treatment? Yes No (if Yes, complete the chart below)

Treatment Facility / Location	Date Attended	Program Length	Completed?
			Yes No
			Yes No
			Yes No

Previous treatment at the Hamilton HART Hub / HUCCHC?	Yes No	**If yes, when**	

Have you ever had periods when you were not using substances? If so, what coping strategies worked?

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IDENTIFIED FAMILY

Which best describes your current relationship status?

Not in a significant relationship In a significant relationship / partnered Married

Please identify your immediate family members below:

Family Member Name	Relationship	Age	Contact with them?	Supportive of treatment?	Problematic substance use?

If you have children, please complete the chart below:

Name of Child	Age	Who do they live with?

LEGAL STATUS

Legal Status:

N/A Awaiting Trial or Sentencing On Probation On Parole Incarcerated

Other (please specify):

Please list all prior convictions			
Parole / Probation Officer		**Phone**	
Lawyer		**Phone**	
FPS #		**OTIS #**	

Do you currently have any outstanding or pending charges, convictions, fines, warrants, court conditions, probation/parole requirements, or other legal restrictions related to any of the following?

Arson or fire-setting
Sexual offence(s)
Violent offence(s) against another person
Weapons offence(s)
Domestic violence-related offence(s)
Other (please specify): _____
None of the above

If you selected any of the above, please provide details, including the current status of the matter (e.g., pending, convicted, on probation, court conditions, etc.):

Yes ☐ No

If yes, please explain	

Are you currently participating in a Drug Treatment Court program? Yes No

Drug Treatment Court Worker			
Phone Number		**Permission to contact?**	Yes No

PHYSICAL HEALTH STATUS

Family Physician or Nurse Practitioner (if applicable)		**Phone Number**	

Please check any that apply to you:

Visual impairment	Mobility concerns	Communicable diseases (e.g. Hepatitis, HIV)
Hearing impairment	Pregnant	Acquired Brain Injury

Please describe your current physical health:

MENTAL HEALTH STATUS

Have you received a mental health diagnosis from a mental health professional?

Within the last 12 months? Yes No Within your lifetime? Yes No

If yes, please explain	

Have you ever attempted suicide? Yes No (if yes, when?):

Please describe your current mental health:

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MEDICATIONS

Current medication(s)	Current dosage(s)
1.	
2.	
3.	
4.	
5.	
6.	
7.	

OPIOID SUBSTITUTION

Are you currently participating in an opioid substitution program? No Yes (if yes, please indicate below)

Methadone Suboxone Sublocade

SUBSTANCE USE HISTORY

What substances are you currently using, and how frequently?

Substance	Frequency	Method of use
1.	1–3 times monthly 1–2 times weekly 3–6 times weekly Daily Binge	
2.	1–3 times monthly 1–2 times weekly 3–6 times weekly Daily Binge	
3.	1–3 times monthly 1–2 times weekly 3–6 times weekly Daily Binge	
4.	1–3 times monthly 1–2 times weekly 3–6 times weekly Daily Binge	
5.	1–3 times monthly 1–2 times weekly 3–6 times weekly Daily Binge	

Please indicate any substances used in the past 12 months (select all that apply):

Substance	Last Date Used	Method of Use
Alcohol		
Amphetamines and other stimulants		
Barbiturates		
Benzodiazepines		
Cannabis		
Cocaine		
Crack		

Ecstasy / MDMA		
Glue / Inhalants		
Hallucinogens		
Heroin / Opium		
Methamphetamines (e.g. crystal meth)		
Other psychoactive substances		
Over-the-counter Codeine		
Prescription Opioids		
Steroids		
Tobacco		
Other (please specify)		

FORM COMPLETION

Date this form was completed	

Thank you for completing this form.