



# Top of the World Ranch



## TREATMENT CENTRE

Box 29, Fort Steele, BC, Canada, V0B1N0  
Toll Free: 1-888-996-6306 Ph:(250) 426-6306 Fx:(250)426-6377  
[help@ranchrecovery.com](mailto:help@ranchrecovery.com) [www.ranchrecovery.com](http://www.ranchrecovery.com)

## Residential Treatment Program Admission Package Overview

### APPLICATION FOR ADMISSION

A referral is not required.

1. **Admission Form:** to be completed by a referral agent if appropriate, or client.
2. **Medical Form:** to be completed by family physician or ranch physician.
3. **Client Self-Assessment:** to be completed by client.
4. **Please** read the full admission package prior to signing and sending to us.

We would like to remind clients and Referral Agent that clients are in retreat for the first week during which there are no visitors or phone contact.

### ADMISSION CRITERIA

1. Persons 18 years of age or over.
2. Clean/sober for one week prior to admission. Exceptions made on case by case basis.
3. Free from mood-altering substances such as benzodiazepines, codeine, and barbiturates. Persons stabilized on anti-depressants and/or methadone are accepted.
4. Medically able to participate in the program, i.e., does not have current physical health problems that would prevent participation in group sessions, i.e. acute back or tooth pain.
5. Emotionally able to participate in group therapy.
6. Able to defer any pending court dates until after treatment and/or established in community for two months post-incarceration.
7. Able to understand and verbally communicate in English.
8. Committed to making changes in life.

Note: Pregnant women are admitted.

This is a daily group therapeutic program with some intense individual counselling weekly.

---

TOP OF THE WORLD RANCH TREATMENT CENTRE Fort Steele, BC

Client Name: _____ DOB: _____
----------------------------------

# Residential Treatment Program

Admission form to be completed by referral agent or client

**A referral is not required.**

Referring Agent: _____	Email: _____
Agency: _____	Agency Code: _____
Address: _____	
_____	
Phone: _____	Fax: _____
Reason for referral, if appropriate: _____	
_____	
_____	
<b>Note: Pending court date(s) must not fall during treatment period.</b>	

## CLIENT INFORMATION

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

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

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ No. & Ages of Children: \_\_\_\_\_

No. of Children Living with Client \_\_\_\_\_ Other Dependents \_\_\_\_\_

## SPOUSAL OR RE-ADMISSION

1. Is this a re-admission? Yes\_\_\_ No\_\_\_ Prior admission date: \_\_\_\_\_
2. \*Is this a spousal admission? Yes\_\_\_ No\_\_\_ Spouse Name: \_\_\_\_\_  
Date of spouse's treatment: \_\_\_\_\_
3. Is client pregnant? Yes\_\_\_ No\_\_\_ Due Date: \_\_\_\_\_
4. Does client have pending charges, court involvement or probation/bail commitments?  
Yes\_\_\_ No\_\_\_  
Please describe \_\_\_\_\_

**\*A spousal admission refers to the spouse of a previously admitted programme graduate. A spousal admission occurs when the spouse of a ranch programmes alumnus desires access to the full treatment programme.**

**ADDICTION SUMMARY**

Primary Substance(s): \_\_\_\_\_

Other Addictive Substances/Behaviours (e.g. gambling, shopping, sex, etc.) etc.:  
\_\_\_\_\_

Cigarette Smoker? Yes\_\_\_ No\_\_\_ How many per day? \_\_\_\_\_

Is client accessing treatment due to consequences of the justice system, employer, trade union (condition of employment, bail, child protection, etc.)? Yes\_\_\_ No\_\_\_

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

	<u>Substance</u>	<u>Date Last Used</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

**Health Assessment**

**Previous Treatment/Counselling  
Complete/Incomplete**

**Dates/# of Sessions**

**Outpatient:** \_\_\_\_\_

**Day:** \_\_\_\_\_

**Residential:** \_\_\_\_\_

**Supportive Recovery:** \_\_\_\_\_

**Detox:** \_\_\_\_\_

Please list physical conditions (e.g. migraines, dental, chronic back pain, withdrawal symptoms) that may impact client's participation in treatment or require medical follow-up during treatment.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the client on methadone maintenance? Yes \_\_\_ No \_\_\_ For how long? \_\_\_\_\_

Prescribing doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Current dosage: \_\_\_\_\_ Any impact on client's alertness after dosing? Yes \_\_\_ No \_\_\_

Are there any of the following disordered eating behaviours currently present? (within last 6 mo.)

	<b>Y/N</b>	<b>How Often</b>	<b>Last Time</b>	<b>How Managing</b>
<b>Binge Eating</b>	_____	_____	_____	_____
<b>Eating Restrictions</b>	_____	_____	_____	_____
<b>Vomiting/Purging</b>	_____	_____	_____	_____
<b>Laxative/Enema Abuse</b>	_____	_____	_____	_____
<b>Diuretic Abuse</b>	_____	_____	_____	_____
<b>Excessive Exercising</b>	_____	_____	_____	_____

**Intensive Residential Treatment Readiness**

To your knowledge, does client have a history of  physical or  sexual abuse? Please detail any prior related counselling.

---

---

Has client ever had a medical diagnosis of psychiatric illness? \_\_\_\_\_

Are any of the following **health risk behaviours** currently present? (within last 6 mo.)

	Y/N	How Often	Last Time	How Managing
<b>Seizures</b>	_____	_____	_____	_____
<b>Suicide Attempts</b>	_____	_____	_____	_____
<b>Self-inflicted</b>				
<b>Violence</b>	_____	_____	_____	_____
(e.g. cutting)				
<b>Hospitalisation for</b>	_____	_____	_____	_____
<b>Psychiatric Illness</b>				

Please Describe:

---

**Any additional concurrent disorder concerns or clinically significant symptoms?**

---

**What individual or therapeutic group counselling has the client experienced in the past six months?**

---

---

**What recent involvement has the client had with self-support groups, i.e. NA, AA, etc.?**

---

**Approximately how many counselling sessions has this client had in the past six months? \_\_\_\_\_**

**What do you see as this client's particular strengths and abilities?**

---

**What challenges might they experience given the intensity and structure at Top of the World?**

---

**What are the overall treatment goals for the client?**

---

**Is follow-up counselling planned for this client post-Top of the World? Yes \_\_\_ No \_\_\_**

**Please add any additional information that might assist Top of the World Treatment Centre counselling team in their work with your client.**

---

---

---

---

---

---

---

TOP OF THE WORLD RANCH TREATMENT CENTRE Fort Steele, BC

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Dear Doctor:

Your patient has applied for admission to the Top of the World Ranch Treatment Centre. The Centre provides an intensive group treatment program for addictions. The Centre is a non-medical facility; so all clients must be medically stabilized and detoxified prior to admission. During treatment emergency care is available on a 24-hour basis through hospital emergency departments off site.

It is expected that clients admitted to our program be able to participate mentally, emotionally, and physically in the intensive program without the need for ongoing medical care. We would appreciate it if you could fill in the accompanying medical form. Your patient is responsible for any fee you charge for this service.

Clients being treated at Top of the World Ranch must have completed withdrawal from alcohol and drugs and have a one-week period of abstinence prior to entry into the program. Potentially addictive medications such as opiates, benzodiazepines and barbiturates are not allowed. Please ensure that any medical condition such as Chronic Pain Syndrome and migraines are well controlled without the need of medications. We do admit clients stabilized on methadone therapy. **If special circumstances exist, please forward information on the medication in question for review by our clinical director and consulting physician.**

Other inappropriate referrals to Top of the World Ranch include persons with the following disorders:

- Paranoid and other fixed delusions
- Auditory, visual, olfactory, or kinaesthetic hallucinations
- Suicidal ideation
- Other thought disturbances which seem out of the person's control and not accessible to efforts for change.

Previous experience indicates these conditions impair the ability of the client to form functional relationships with other clients and staff, and usually lead to failure to complete the program.

If in doubt, please feel free to contact Top of the World Ranch Treatment Centre for further discussion about your patient's needs. If you become aware of any reason why your patient would not be appropriate for the program, please inform us as soon as possible.

Thank you for completing the attached form.

# MEDICAL ASSESSMENT FORM

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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

**Medical History** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Psych History** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical History** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_ Anakit \_\_\_\_\_

## LAB

Liver Function Test      Yes \_\_\_\_\_      No \_\_\_\_\_

HIV      Yes \_\_\_\_\_      No \_\_\_\_\_

Hepatitis B      Yes \_\_\_\_\_      No \_\_\_\_\_

Hepatitis C      Yes \_\_\_\_\_      No \_\_\_\_\_

---

TOP OF THE WORLD RANCH TREATMENT CENTRE Fort Steele, BC

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**DRUG HISTORY**

<u>Name of Drug</u>	<u>Date of last use</u>
Alcohol	_____
Cannabis	_____
Cocaine	_____
Opiates	_____
Amphetamines (including crystalmeth)	_____
Benzodiazepines	_____
Other	_____

**REVIEW OF SYSTEMS**

ENT	_____	CHEST	_____
CVS	_____	ABD	_____
NEURO	_____	M/SK	_____
SKIN	_____	ENDO	_____
GYNE	G _____ P _____ A _____	CYCLE	_____

**PHYSICAL EXAM**

HEIGHT	_____	WEIGHT	_____	BP	_____	PULSE	_____
ENT	_____	CHEST	_____				
CVS	_____	ABD	_____				
NEURO	_____	M/SK	_____				
SKIN	_____	ENDO	_____				

SUMMARY \_\_\_\_\_  
\_\_\_\_\_

Client is medically and physically able to participate in an intensive group-counselling program.

Physician \_\_\_\_\_

**Client Self-Assessment Form**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

To assist in your treatment at the Top of the World Ranch Treatment Centre, please complete the following as honestly and thoughtfully as you can. This form is to be returned with your financial and medical forms.

**1. My biggest block to staying healthy and sober right now is:**

---

---

**2. My personal strengths right now are:**

---

---

**3. Needs (liabilities, weaknesses):**

---

---

**4. Abilities (skills, aptitudes, capabilities, talents, competencies):**

---

---

**5. Preferences (those things the client feels will enhance his/her treatment experience):**

---

---

**6. The changes I would like to see in myself by the end of treatment are:**

- In the area of addiction: \_\_\_\_\_

\_\_\_\_\_

- In the area of physical health: \_\_\_\_\_

\_\_\_\_\_

- In the area of emotional health: \_\_\_\_\_

\_\_\_\_\_

---

---

TOP OF THE WORLD RANCH TREATMENT CENTRE Fort Steele, BC

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

- 10 -

- In the area of inner wisdom/spiritual growth: \_\_\_\_\_

- In the area of social/relationship growth: \_\_\_\_\_

7. My fears about treatment are: \_\_\_\_\_

8. Situations in my life that might interfere with treatment are: \_\_\_\_\_

### **Additional Information**

1. A \$2000 non-refundable deposit is required to secure your space & treatment date.
2. The remainder of payment is due upon arrival and is non-refundable.

\*The only exceptions are as follows:

- a. When a medical discharge; initiated by Top of the World Ranch Treatment Centre staff for previously disclosed ailments; is determined to be necessary.
- b. For medical discharge initiated by a medical physician concerning an ailment(s) not previously known to the client or treatment centre staff.

\*When a medical discharge as described above (a & b) takes place; the client will receive a 50% prorated refund for the remainder of their planned stay with us, beginning upon the day following the date of discharge. This refund is not inclusive of the client deposit. This refund is not inclusive of client discharge for any other cause.

**Thank you for completing the form.**

**Top of the World Ranch Treatment Centre**