BRIDGEPOINT
CENTER FOR EATING DISORDERS

PART A
completed by Applicant

Program Applying For :

◯ **Retreat** Date: _____ Alternate Date: _____ *(maximum of 3 programs applied for at a time)*
◯ **Module 1** Date: _____ *(Parts B & C are required for Modules, or as requested)*
◯ **Module 2** Date: _____
◯ **Module 3** Date: _____

Referral Source: ◯ Self-referral ◯ Referring Professional Former Health Region: _____
Referral Contact Info:_____

Previous Admission to BridgePoint: YES NO * Previous discharge from program due to breach of Walls and Boundaries will impact future admissions. Discharge involving violence, safety, alcohol/substance use, or confidentiality will not be readmitted onsite.

Applicant Information

Name: ◯ Male ◯ Female ◯ Other _____ Preferred Pronoun:	**DOB:**	**AGE:**
Health Card #: Issuing Province: Expiry:		
Address: Box/Street City, Prov Postal Code		

Contact Information *Please provide phone numbers where messages **can** be left.*	Home Phone:	Cell Phone:	Work Phone:
Email Address:			
Preferred Method of Communication: ◯ Phone Call ◯ Email ◯ Other			

Safety Contact *Which Whom BridgePoint may share/receive your information.*	**Name**: *Contacted in emergency situation or early departure from program*	Home Phone	Cell Phone
Relationship:	Street Address/City:	Email:	

Health Care Provider, Person or Agency	**Doctor**:	Phone:
	Counsellor:	Phone:

◯ I acknowledge that BridgePoint is a peanut free and scent sensitive facility and will **not** bring scented products or peanuts.
◯ BridgePoint is not a medical facility and I will be able to maintain medical and psychiatric stability during programming.

Applicant Signature: _____ **Date:** _____

Please return completed form as legibly as possible and return to: Admissions, BridgePoint Center
Fax: (306)935-2241 Email: bridgepoint@sasktel.net Box 190 Milden, SK. S0L 2L0 Phone: (306) 935-2240
INCOMPLETE OR ILLEGIBLE APPLICATION FORMS WILL NOT BE PROCESSED
Please note that we are not a crisis line and do not provide any emergency services.

Eating Disorder Behaviours

What eating disorder symptoms or behaviours have you experienced?

Overeating/binging	◯ None	◯ Past	◯ Current	Frequency:
Purging (vomiting/laxative use, etc.)	◯ None	◯ Past	◯ Current	Frequency:
Under-eating/restricting food intake	◯ None	◯ Past	◯ Current	Frequency:
Excessive or compulsive exercise	◯ None	◯ Past	◯ Current	Frequency:
Ongoing dieting or calorie counting	◯ None	◯ Past	◯ Current	Frequency:
Use of diuretics, laxatives, or diet pills	◯ None	◯ Past	◯ Current	Frequency:
Changes in weight during the past year	◯ Gain	◯ Loss	◯ Stable	How Much:
Other:	◯ None	◯ Past	◯ Current	Frequency:

Daily Reported Food Intake: ◯ Less than 1 meal/day ◯ 1 meal/day ◯ 2+ meals/day (including snacks)

Describe your current experience with food:

_____

_____

_____

Years with disorder: _____ Current Diagnosis (self-perspective): _____ Age first self-diagnosed: _____

Current Health

Current or ongoing medical or mental health concerns:

_____

_____

Date of last GP Visit: _____ Any concerns: _____

Date of last physical: _____ Any concerns: _____

Amenorrhea ◯ Yes ◯ No Date of Last Period: _____

Have you ever been hospitalized? ◯ Yes ◯ No If yes, date of last admission/duration/reason:_____

◯ Diabetes ◯ Pregnant (#weeks __) ◯ Substance Use/Dependency ◯ Mobility Issues ◯ CPAP Machine

Special Accommodation Requests:_____

◯ Appointments during programming _____ (*must be approved and arranged prior to admission*.)

◯ Medical Marijuana Usage (*must be approved for use onsite prior to admitting. Send prescription and licence with application*.)

◯ Allergies (List type/severity/Tx) _____ ◯ Epi-pen

◯ Service Animal Type: _____ ***Contact BridgePoint to request approval and for separate application. Cannot attend without prior approval.***

What plays an integral part in your recovery? What other supports or resources would be helpful?

_____

_____

_____

_____

Current Supports:

◯ Mental Health Team	◯ Psychologist	◯ Therapist
◯ Psychiatrist	◯ Dietitian	◯ Day Program
◯ Self-help groups	◯ Group Home	◯ Others

What other treatments have you accessed in the past? Or since you were last here? What are you working on with your supports?

_____

_____

_____

_____

PARTICIPANT NAME:_____ **Date:** _____

Participant Profile (FOR STATISTICAL USE - DOES NOT FORM PART OF YOUR RECORD)

Check all that apply:

◯ Depression	◯ Anxiety	◯ Hoarding	◯ Obsessive compulsive	◯ Other:
◯ Social isolation	◯ Manias, mood swings	◯ Stealing/shoplifting	◯ Memory problems	◯
◯ Chronic thoughts of suicide	◯ Perfectionism	◯ Sexual compulsivity	◯ Substance use/addiction	◯
◯ Suicide attempts (past year)	◯ Attention deficit disorder	◯ Bipolar	◯ Borderline personality	◯
◯ Trauma/PTSD	◯ Schizophrenia	◯ Trichotillomania	◯ Sensory disorder	◯
◯ Gambling addiction	◯ Shopping addiction	◯ Dissociative identity	Other:	Other:

Personal History of Known Abuse/Trauma

◯ Physical	◯ Verbal	◯ Emotional	◯ Sexual	◯ Neglect
◯ Adverse Childhood Events	◯ Financial	◯ Spiritual	Other:	

_____

Personal History of Self Harm/ Suicide Attempts

◯ Past history of Self Harm	◯ Present Self Harm	◯ No history of Self Harm	◯ Past Suicide Attempt	◯ Recent Suicide Attempt (2 months)

Quality of Life- Where has the eating disorder had the greatest impact on your life?

◯ Employment	◯ Relationships	◯ Housing/Food Insecurity	◯ Financial	◯ Spiritual
◯ School	◯ Social/recreational	◯ Legal	◯ Other	

External Agency Diagnosis (DSM-5 Feeding and Eating Disorders): ***Check one below*** *(most recent diagnosis)*

Age diagnosed: _____	◯ Anorexia (AN)	◯ Bulimia Nervosa (BN)	◯ Binge-Eating Disorder (BED)
◯ Other Specified Feeding or Eating Disorder (OSFED)	◯ Unspecified Feeding or Eating Disorder	◯ No formal diagnosis	Other:

Occupation: _____ **Highest Level of Education:** _____

◯ Employed	◯ Unemployed	◯ Unemployed	◯ Disability – SAID	◯ Disability – work plan	◯ Student

Marital Status: _____ **Children: Age/Sex** _____

Family of Origin *(Is there anything about your family that would be important for us to know?)*

_____

Internal vs. External Motivation

Out of 100%, what percentage of you is motivated to be here for yourself vs others? Yourself ____% Others _____% (adds up to 100%)

What strengths do you bring with you to BridgePoint and your recovery? *ie. Humor, perseverance, tenacity, stubbornness, etc*

_____

Client Identified Resources: *Who or what plays an integral part of your recovery? i.e pets, spirituality, music, friends, etc?*

_____

_____

_____

What other information would you like us to know?

Please explain: _____

_____

_____

_____

You will be contacted about the status of your application. Spots are not confirmed until verbal or written confirmation is provided.

Saskatchewan Health Authority
Mental Health and Addictions Services
In Partnership with
BridgePoint Center Inc.

NAME: _____

HSN: _____

DOB: *(dd/mm/yyyy)* _____

MRN#: _____

TERMS OF SERVICE

Welcome to Mental Health and Addiction Services working in partnership with BridgePoint. As you and/or your child work together with your Service Provider, options for care and service will be explained so that informed decisions can be made, and goals set. As part of providing service to you, your assigned Service Provider will need to collect and record personal information that is relevant to your current needs. Goals and a treatment plan for counselling that includes approximate length of therapy will be developed with your clinician and regularly reassessed to ensure a successful outcome.

To assist with treatment planning, the service plan that you and/or your child develop with your Service Provider, will be documented and may be shared with current and future assigned members of your treatment team. Such individuals may include but are not limited to Psychiatrists, Family Physicians, other Community Service Providers, and the person who referred you to Mental Health and Addictions Services.

Mental Health and Addictions Services develops a case file on MENTAL HEALTH AND ADDICTION INFORMATION SYSTEM (MHAIS) regarding services provided for all individuals. There are laws and policies that regulate how information is to be kept, when it can be shared and with whom. At any point, you can request to have access to your file. You will be provided the requested documents or the reason the documents cannot be provided according to legislation. You can also request at any time to see who has had access to your file. Confidentiality is limited by requirements of the Criminal Code of Canada, the Child and Family Services Act, the Mental Health Services Act, and the Health Information Protection Act. Information will be released under the following circumstances:

1. You request information be shared with another individual or agency, and sign a release statement.
2. There is reason to believe there is serious and imminent risk of harm to you or others.
3. There is reason to believe that a child is in need of protection.
4. Information is required by law or the Courts;
5. Inpatient care or treatment is required within the Saskatchewan Health Authority or partnering agency.
6. There is reason to believe that you pose a risk to operate a motorized vehicle and/or airplane.

Your clinical record will be maintained for 10 years and your child's clinical record will be maintained 20 years after you complete services in a secure location. If you feel unclear at any time about the issue of confidentiality, or would like a copy of these regulations, please let your service provider know.

A request may be made of you and/or your child to participate in training activities. Participation is optional. Your service provider may be in a provisional/probationary period and will be working under the direct supervision of a fully qualified supervisor.

Clinical supervision is provided to all staff, and files will be reviewed for supervision purposes.

Part of treatment is providing a safe environment for all clients and staff. This includes refraining from using substances prior to coming to appointments and during programming, and not bringing items or weapons to the center that could harm self or others.

BridgePoint has a scent free and peanut free policy; therefore, we ask you to refrain from using fragrances and bringing peanut products. Thank you for your attention to these important details.

I understand the above Terms of Service as explained to me and/or my child. I also understand that I may ask for a review of these terms at any time and have the right to ask questions about the services I, or my child, receives, to make my own suggestions and to discontinue services at any time.

NOTE: Please Select Signatory Type:

☐ **CLIENT** ☐ **LEGAL GUARDIAN** ☐ **REPRESENTATIVE**

Name *(print LEGIBLY)* _____

_____
Client/Legal Guardian/Representative Signature

_____
Date