



Eating Disorder Recovery Group for Youth

**ONLINE INTENSIVE CLOSED GROUP
MARCH 3-31, 2021**



Guided by a multi-disciplinary team of eating disorder professionals, this 5-week program combines the convenience of virtual access to provide meaningful discussion, tools, and strategies to support youth who are experiencing disordered eating. A formal diagnosis is not required to join.

This program is specifically designed to address challenges many youths are experiencing, with tailored evidence-based content and processing available in an online closed group that allows space for learning and integration between each session. This group is open to youth 12-18 years of age and is free of charge for Saskatchewan residents.

To apply, please complete this intake package and return to BridgePoint. Upon review, a registration link will be emailed to the applicant and/or guardian.



BridgePoint Center for Eating Disorders Virtual Care Informed Consent

I, (name) _____, agree to participate in the residential programming offered by BridgePoint Center Inc. (Operating as BridgePoint Center for Eating Disorders and hereinafter referred to as "BridgePoint"), of Mildred, Saskatchewan.

I HEREBY REMISE release and forever discharge BridgePoint and the Saskatchewan Health Authority from any liability, actions, suits, damages, claims or judgments that may result from any injury to my property or person for any reason whatsoever, including but not limited to any act or omission of BridgePoint or its agents, whether negligent or otherwise. I AM VOLUNTARILY participating in virtual programming offered by BridgePoint. I am signing this document of my own free will.

Due to the ongoing risk of the COVID-19 virus, BridgePoint Center has canceled all in-person groups until we get approval from SHA to resume services. In light of the COVID-19 precautions, we have been working hard to develop alternative ways to provide support to our community. Online and in-person group therapy and educational workshops are a unique environment in which a group of people who are likely experiencing similar difficulties come together to both give and receive help from one another. BridgePoint Center attempts to create an environment where honest, interpersonal exploration will occur that will benefit all members. To create this environment, certain guidelines need to be agreed upon by each participant. As this is a new pilot project, spots are limited.

CONFIDENTIALITY

Groups are effective because individuals feel safe to share private information in a confidential atmosphere. Every member of the group must agree to uphold the confidentiality of the therapeutic setting.

- ✓ Members agree to keep the names and identities of other group members confidential.
- ✓ All group/workshop materials and content are confidential. Please do not share, photocopy, record, screenshot, video tape or audio tape sessions unless agreed upon for therapeutic purposes.

ATTENDANCE

Group therapy is successful (as is any form of therapy) when there is regular attendance on behalf of the participants. If you cannot attend a group meeting, please email us to let us know as soon as possible. In your message please also indicate whether or not it is permissible for us to share why you are absent. Please arrive on time. If you miss and cancel late (less than 24 hours ahead of time) 2 times, we reserve the right to remove you from the group.

ACTIVE PARTICIPATION

Members of effective groups actively share thoughts, reactions, and feelings during group meetings as a way of increasing their self-understanding and contributing to the personal growth of other

members. To support that goal, facilitators will strive to establish and maintain a climate of respect within the group. Each member will undoubtedly share in different ways and be comfortable with different levels of disclosure. It is requested that as a participant you share what is comfortable and actively listen and attend to other group members. Participation does not necessarily mean talking. It can also mean listening to what other members have to say. No one will ever be forced to share anything that they are not comfortable sharing.

WITHDRAWAL

Members will let the group know in advance if they are leaving the group. Group participation is voluntarily. If you or the facilitator(s) determine that the group is not serving your needs, you will be referred to other options.

ONLINE SESSIONS

All of BridgePoint's online workshops and groups are conducted using the Pexip, which is an approved platform by Saskatchewan Health Authority. Pexip is also committed to protecting personal health information consistent with the requirements of the Personal Health Information Protection Act, 2004. To learn more about Pexip's commitment to privacy, visit:

<https://https://www.pexip.com/security/security-data-protection-otn.ca/about-us/privacy/>

Should it be discovered that you are in breach of any of the policies above, the facilitator(s) and/or other group members may ask that you terminate your participation in group therapy.

In exchange for allowing me to participate, I hereby waive and covenant not to sue, and further agree to indemnify, defend, and hold harmless, BridgePoint Center Inc. and its officers, directors, employees, contractors, and volunteers (collectively, the "Waived Parties"), from any and all liability, claim(s), demand(s), cause(s) of action, damage(s), loss or expense, including court costs and reasonable attorney's fees of any kind or nature whatsoever ("Liability") which may arise out of, result from, or relate to my participation. I further agree that if, despite this Agreement, I, or anyone on my behalf, make a claim for Liability against any of the Waived Parties, I will indemnify, defend, and hold harmless the Waived Parties from any such Liability which may be incurred as a result of such a claim that I might have against the Waived Parties or anyone associated with the educational support group.

I understand all of the above and agree to the above terms.

Participant Signature: _____

Guardian Signature: _____

Date: _____



BRIDGEPOINT CENTER VIRTUAL PROGRAMMING COMMITMENT

Virtual group programs require a sense of community to operate effectively. It is the intention of BridgePoint Center to create a safe, nurturing, healing environment for program participants and team members. The following boundaries and walls were developed to promote a safe residential experience in community.

Boundaries

Boundaries are guidelines for behavior, and imply a degree of flexibility.

1. I will participate in the full program schedule.
2. I understand that I am required to have my video and microphone function available and turned on throughout the group (except while I have my microphone on "Mute").
3. I will ensure I have a private environment to ensure confidentiality and will use headphones during sessions.
4. I will sign in to the call at least 5 minutes in advance of the session.
5. I will be punctual and understand that late entry may not be permitted once the virtual room is locked.
6. I will practice courteous and responsible behavior. I will demonstrate adequate impulse control by not interrupting a participant's process or giving advice.
7. I will not use my cell phone during any group activities (unless for the use of accessing this program).
8. During a virtual retreat, if I choose to leave the program prior to its completion, I agree to consult team.

Walls

Walls provide a firm structure to ensure the safety of individuals participating in BridgePoint programming.

1. Confidentiality at BridgePoint is essential. I will not discuss the experiences of other participants. I will not name or describe other participants. I will not take pictures of group participants or chats. ("*Participants*" is all encompassing and includes team).
2. BridgePoint is a place where people of **all** sizes, shapes, genders, abilities, and backgrounds can gather to celebrate all bodies, support one another as we work toward body acceptance, and build a more inclusive community that values all people. I will preserve this inclusive community by not commenting on anyone's body image.
3. BridgePoint has a **zero tolerance** policy for behavior that jeopardizes personal safety. Violent behavior is not tolerated. **Violence is defined as verbal, physical, sexual or emotional aggressive behavior. Violence can be, but is not limited to raised voices or tone, sarcasm, threats, comments or mannerisms.**
4. I will not consume alcohol, use drugs (including marijuana *unless previously approved as medically necessary*), or other mind altering substances while attending BridgePoint virtual programming.
5. In order to remain a participant in BridgePoint programming, participants must remain medically and psychiatrically stable during the entire program. Should I feel like I am not able to keep myself safe I will reach out and engage outside resources as necessary (see list attached).

I understand the BridgePoint Center "Virtual Programming Commitment" and agree to abide by BridgePoint Boundaries and Walls as presented. I understand that I am responsible for my own behavior. I understand that BridgePoint team members are available to provide support to me and assist me to continue my personal recovery.

Signature of Participant _____

Date _____

Signature of Guardian _____

Date _____

Name of Guardian _____



CONSENT FOR RELEASE OF INFORMATION

SHOULD ANY INDIVIDUAL/AGENCY CHANGE A NEW FORM WILL BE REQUIRED

I, _____, BIRTH DATE: _____, OF _____
(Name) (YY/MM/DD) (Community, Province)

hereby consent to allow BridgePoint Center Inc. (hereinafter referred to as "BridgePoint") to release information from their clinical records:

To: _____

DOCTOR *(Name and address of individual and/or agency to receive information)*

And: _____

COUNSELLOR *(Name and address of individual and/or agency to receive information)*

And: _____

PHARMACIST *(Name and address of individual and/or agency to receive information)*

And: _____

PSYCHIATRIST *(Name and address of individual and/or agency to receive information)*

And: _____

DIETITIAN *(Name and address of individual and/or agency to receive information)*

And: _____

FAMILY MEMBERS/FRIENDS *(Name and address of individual and/or agency to receive information)*

And: **SASKATCHEWAN HEALTH AUTHORITY (Mental Health and Addictions Services)** as required during their partnership with BridgePoint during programming.

Signature of Participant (or Guardian if under 16)

Date of Participant Signature

Signature of Witness

Date of Witness Signature

This consent will expire only upon written notification, from you (Participant), advising BridgePoint "consent is withdrawn", and by specifically naming to whom you do not want information released.



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: _____ **Youth Support Group** Date: _____

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

Referral Contact Info: _____

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

<input type="radio"/> Mental Health Team	<input type="radio"/> Psychologist	<input type="radio"/> Therapist
<input type="radio"/> Psychiatrist	<input type="radio"/> Dietitian	<input type="radio"/> Day Program
<input type="radio"/> Self-help groups	<input type="radio"/> Group Home	<input type="radio"/> 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:

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

Personal History of Known Abuse/Trauma

<input type="checkbox"/> Physical	<input type="checkbox"/> Verbal	<input type="checkbox"/> Emotional	<input type="checkbox"/> Sexual	<input type="checkbox"/> Neglect
<input type="checkbox"/> Adverse Childhood Events	<input type="checkbox"/> Financial	<input type="checkbox"/> Spiritual	Other:	

Personal History of Self Harm/ Suicide Attempts

<input type="checkbox"/> Past history of Self Harm	<input type="checkbox"/> Present Self Harm	<input type="checkbox"/> No history of Self Harm	<input type="checkbox"/> Past Suicide Attempt	<input type="checkbox"/> Recent Suicide Attempt (2 months)
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Quality of Life- Where has the eating disorder had the greatest impact on your life?

<input type="checkbox"/> Employment	<input type="checkbox"/> Relationships	<input type="checkbox"/> Housing/Food Insecurity	<input type="checkbox"/> Financial	<input type="checkbox"/> Spiritual
<input type="checkbox"/> School	<input type="checkbox"/> Social/recreational	<input type="checkbox"/> Legal	<input type="checkbox"/> Other	

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

Age diagnosed: _____	<input type="checkbox"/> Anorexia (AN)	<input type="checkbox"/> Bulimia Nervosa (BN)	<input type="checkbox"/> Binge-Eating Disorder (BED)
<input type="checkbox"/> Other Specified Feeding or Eating Disorder (OSFED)	<input type="checkbox"/> Unspecified Feeding or Eating Disorder	<input type="checkbox"/> No formal diagnosis	Other:

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

<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Disability – SAID	<input type="checkbox"/> Disability – work plan	<input type="checkbox"/> Student
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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.