HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

Bed-based Family Retreat Weekend: Referral Package Information Sheet

Please note that this package can be completed by either a referral source or by the person looking for services (self-referral).

Just a reminder that the Family Retreat Weekend is meant for those family members who are being impacted by a loved one who struggles with gambling and/or digital dependency (video games/general internet overuse).

PLEASE ENSURE THAT ALL OF THE REQUIRED FORMS ARE COMPLETED FULLY!

THE FOLLOWING FORMS MUST BE INCLUDED AT THE TIME OF SUBMISSION with the exception of #5 below:

1. BED-BASED PROGRAM REFERRAL INFORMATION FORM
2. CATALYST ADMISSION FORM
3. PG SIGNIFICANT OTHERS IMPACT SCALE (PG-SOIS)
4. GAIN-SS
5. MEDICAL CLEARANCE FORM* to be provided to your family doctor for completion (the medical clearance form does not have to be completed at the time you submit your referral package however, must be completed and submitted before you attend your respective family retreat cycle)
6. BED-BASED PROGRAM GUIDELINES – signed by the person seeking services

FAX OR EMAIL COMPLETED REFERRAL PACKAGE TO 519-254-0093 OR laurie.gignac@hdgh.org

For questions and assistance, please contact our Program Secretaries at 519-254-2112 or Intake Worker at 519-257-5111 ext. 76985

HÔTEL-DIEU GRACE
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BED-BASED FAMILY RETREAT WEEKEND REFERRAL INFORMATION FORM

1. REFERRAL DATE:	2. GENDER ( ) MALE ( ) FEMALE ( ) OTHER	3. FIRST & LAST NAME:	4. PHONE: ( ) Ok to call? YES ( ) NO ( ) Ok to leave a message YES ( ) NO ( )
5. ADDRESS:		6. CITY: POSTAL CODE:	7. DATE OF BIRTH DAY_____MONTH_____YEAR _____
8: Ok to email? YES ( ) NO ( ) Email address: _____		9. LOVED ONES DEPENDENCY (check): ( ) Gambling ( ) Video Games/General internet overuse	10. LOVED ONES HISTORY: Is their dependency ongoing ( ) Yes ( ) No How long have they had their dependency? _____
11. ANY MENTAL ILLNESSES Y ( ) N ( ) DIAGNOSIS:_____ DIAGNOSIS:_____ DIAGNOSIS: _____		12. PHYSICAL ISSUES AT PRESENT:	13. ALLERGIES IF ANY (medicines, food, other): 14. DIET RESTRICTIONS IF ANY:
15. MEDICATIONS CURRENTLY TAKING:		16. LANGUAGES SPOKEN: 17. CLIENT ETHNICITY:	18. RELATIONSHIP STATUS: 19. Can the client read/write English? YES ( ) MODERATELY ( ) NO ( )
20. CHARGES PENDING: YES( ) NO( ) IF YES, LIST CHARGES:		21. CURRENTLY ON PROBATION/PAROLE: YES ( ) NO ( )	22. PROBATION OFFICER: PHONE #:

23.	**YES**	**NO**
Do you have suicidal ideation?		
Do you have a history of arson?		
Do you have a history of violence?		

24. Does this person have a history of substance abuse? YES ( ) NO ( ) If yes, please list substances of choice:	25. ARE YOU AWARE THAT THIS PROGRAM FOCUSES ON YOU AND NOT YOUR LOVED ONE? ( ) YES ( ) NO

HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

CENTRE FOR PROBLEM GAMBLING AND DIGITAL DEPENDENCY
CATALYST ADMISSION INFORMATION

OSAB KEY# (Office Use Only) _____ (Initials, DOB (yyyy/mm/dd) male – 1, female – 2)	CLIENT NAME:	PRIMARY COUNSELLOR:

ADMISSION INFORMATION

Admission Date: dd _____ mm _____ yyyy _____ Client Type: ❒Gambler ❒Family Member/Friend

LEGAL STATUS

Treatment Mandated/ Required by:

❒None ❒Choice between treatment or jail ❒Condition of Probation/Parole
❒Child Welfare Authority ❒Condition of employment ❒Condition of school
❒Condition of family ❒Other ❒Unknown

Legal Status
❒No Problem ❒Awaiting trial/sentencing ❒Probation ❒Parole ❒Incarcerated ❒Other ❒Unknown

Young Offender? ❒Yes ❒No ❒Unknown ❒Not Applicable
Probation: Start date: dd_____mm _____ yyyy _____ End date: dd_____ mm _____ yyyy _____

RELATIONSHIP STATUS

❒Married/Partnered/Common Law ❒Single (Never Married) ❒Widow/Widower ❒Separated/Divorced ❒Unknown

EMPLOYMENT STATUS

❒Employed/Full Time, includes self employed ❒Employed Part-time ❒Unemployed (Looking for Work)
❒Student/Retraining
❒Disabled (Not Working) ❒Not in Working Force (e.g. Homemaker) ❒Retired ❒Unknown

Employer: _____ OK to Call: YES ❒ NO ❒

EDUCATION

❒No Formal Schooling ❒Some Primary School ❒Primary School ❒Some Secondary School
❒Completed Secondary School ❒Some Community College ❒Completed College ❒Some University
❒University Completed ❒Unknown

INCOME SOURCE

❒Disability Insurance ❒ Employment ❒Employment Insc. (UI). ❒Family Support.
❒None ❒ODSP (Ont. Disability) ❒ Ontario Works (Welfare) ❒Other
❒ Other Insurance (excluding Emp. Insc) ❒ Retirement Income ❒ Unknown

PRESENTING ISSUES AT ADMISSION

❒Gambling ❒Gambling by other

❒Addiction/Substance Abuse by Others

❒Physical Abuse ❒Mental/Emotional Abuse ❒Sexual Abuse

❒Financial

❒Financial/Bankruptcy

❒Legal

❒Other Disorders: _____

PRESENTING PROBLEM SUBSTANCES (leave blank if none)

(Frequency of use in last 30 days)

1st _____ ❒did not use ❒1 – 3 times/mthly ❒1 – 2 times/week ❒3 – 6 times/week ❒Daily ❒Binge

2nd _____ ❒did not use ❒1 – 3 times/mthly ❒1 – 2 times/week ❒3 – 6 times/week ❒Daily ❒Binge

3rd _____ ❒did not use ❒1 – 3 times/mthly ❒1 – 2 times/week ❒3 – 6 times/week ❒Daily ❒Binge

SUBSTANCES USED IN LAST 12 MONTHS (leave blank if none)

❒ None	❒ Benzodiazepines	❒ Glue/Inhalant	❒ Script. opiates
❒ Unknown	❒ Cannabis	❒ Hallucinogens	❒ Tobacco
❒ Alcohol	❒ Cocaine	❒ Heroin/Opium	❒ Other _____
❒ Amphetamines	❒ Crack	❒ Over the counter codeine	
❒ Barbiturates	❒ Ecstasy	❒ Other/Psycho – Active	

GAMBLING

Treatment Plan: ❒ Treated within this agency ❒ Declined treatment ❒ Treatment Plan not established

❒ Not Applicable ❒ Referred to a designated gambling agency

Gambling Activities Engaged in Past 12 months:

❒ Bingo

❒ Slot machines

❒ Gaming machines (other than slots)

❒ Casino -Card/table games

❒ Non-Casino Card/Table Games

❒ Horse races

❒ Sports betting

❒ Lottery tickets

❒ Instant win/ scratch tickets

❒ Internet gambling

❒ Gambling with stock market/real – estate

❒ Betting on games of skill

❒ Betting on outcome of events

❒ Other _____ ❒ None ❒ Unknown / Data unavailable

OSAB Required Gambling Data Form

1. Are you seeking help for:
   - ❒ Your own difficulties related to a family member/significant other's gambling. STOP HERE
   - ❒ Your own gambling problem. PLEASE CONTINUE
   - ❒ Both: PLEASE CONTINUE
2. Looking back now, for how many years has your gambling affected your life in negative ways?

   Years _____ Months _____

3. Please indicate how long it has been since you last gambled:
   (Record the number of years, months, weeks, or days)

   Years _____ Months _____ Weeks _____ Days _____

4. Please indicate whether:
   - ❒ You came to this agency specifically for gambling treatment
   - ❒ Your gambling problem surfaced in the course of other treatment

5(a) Please indicate how often you engaged in each of the following gambling activities in the past 12 months:

Did not gamble in the past 12 months: ❒

		Did not gamble	Less than once per month	1 –3 times a month	1 – 2 times weekly	3 – 6 times weekly	Daily	Unknown
1.	Played cards							
2.	Played Mahjong							
3.	Played live KENO							
4.	Played Roulette							
5.	Bets on horses, dogs, or other animals							
6.	Bets on sports (e.g. Sports Select, bookie)							
7.	Bets on dice games (e.g. craps)							
8.	Bought lottery tickets (Pick 3, 6/49)							
9.	Bought scratch tickets							
10.	Bought tear-open tickets (Nevada)							
11.	Played Bingo							
12.	Played stock options/commodities market							
13.	Played VLT's							
14.	Played slots or other non-VLT machines							
15.	Internet Gambling							
16.	Played pool/golf/or other game of skill							
17.	Sports pools							
18.	Betting on random events/informal bets							
19.	Other							

5 (b) Please indicate the top three types of gambling problems, using the activity numbers in
Major _____ 1St other _____ 2nd other _____

6 (a) Please indicate how often you gambled in each of the following locations in the last 12 months.

		Did not gamble	Less than once a month	1 – 3 times a month	1 – 2 times weekly	3 – 6 times weekly	Daily	Unknown
1.	In a commercial Casino							
2.	In a charity gaming club							
3.	In a bingo hall							
4.	At the race track							
5.	At an off-track betting location							
6.	On the Internet							
7.	On the television (bingo at home)							
8.	On the telephone (e.g. stocks, sports, betting)							
9.	Lottery kiosk/outlet							
10.	In family/friends setting							
11.	In a social club							
12.	In a restaurant/bar							
13.	In a school setting							
14.	In a work setting							
15.	In a senior's center/home							
16.	In a custody/correctional facility							
17.	Somewhere else in the community							

6 (b) Please indicate the top three locations for gambling, using the numbers in 6 (a)

Major _____ 1st other _____ 2nd other _____

7. Thinking about the times you gambled in the past 12 months, what percent were:
(Numbers should add up to 100%; leading zeros not necessary)

(a) in Ontario _____ % (b) in another province _____% (c) Outside of Canada _____%

HEALTH STATUS

Visual Impairment: ❒ YES ❒ NO ❒ Unknown

Hearing Impairment: ❒ YES ❒ NO ❒ Unknown

Mobility/Physically Impairment: ❒ YES ❒ NO ❒ Unknown

Pregnant: ❒ YES ❒ NO

Non-Medical Intravenous Drug Use:

❒ Never injected ❒ Injected prior to one year ❒ Injected in past 12 months ❒ Unknown

Number of Overnight Hospitalizations in last 12 months for physical problems:	Reason for most recent Hospitalization:

Diagnosed with a Mental Health problem by a qualified Mental Health Professional:

Within the last 12 months: ❒YES ❒NO ❒ Unknown Within Lifetime: ❒YES ❒NO ❒Unknown

Most Recent Diagnosis #1: _____ Most Recent Diagnosis #2: _____

Hospitalized for a Mental Health problem?

Within the last 12 months: ❒ YES ❒ NO ❒ Unknown Within lifetime: ❒ YES ❒ NO ❒ Unknown

Received Treatment for a Mental Health, Emotional, Behavioural or Psychological problem from a Community Mental Health Program or Professional:

Currently: ❒ YES ❒ NO ❒ Unknown Within lifetime: ❒ YES ❒ NO ❒ Unknown

Within last 12 months: ❒ YES ❒ NO ❒ Unknown

Prescribed Medication for a Mental Health Problem: Currently: ❒ YES ❒ NO ❒ Unknown

Within last 12 months: ❒ YES ❒ NO ❒ Unknown Within lifetime: ❒ YES ❒ NO ❒ Unknown

Health Conditions/Problems: (circle applicable): Allergies, Blood Pressure, Cancer, Chronic Pain, Diabetes, Eating Disorder, HIV/AIDS, Heart Disease, Lice/Scabies, Liver Disease, Menstrual/Menopausal/ Pancreatitis, Respiratory, STD, Stomach, Thyroid, Tuberculosis

Provider of Primary Health Care: _____

Prescribed Drugs: Methadone: ❒ YES ❒ NO ❒ Unknown

Drugs Currently Prescribed: _____

_____

_____

_____

_____

THE PROBLEM GAMBLING SIGNIFICANT OTHER IMPACT SCALE (PG-SOIS)

NAME:_____ DATE:_____

In the past 3 months, how often:	**NOT AT ALL (0)**	**RARELY (1)**	**SOMETIMES (2)**	**OFTEN (3)**
Have you or your family experienced financial hardship as a result of the other person's gambling?				
Have you experienced feelings of sadness, anxiety, stress or anger due to the other person's gambling?				
Has the quality of your relationship with the other person been affected by his/her gambling?				
Has your social life been affected by the other person's gambling?				
Has your ability to work or study been affected by the other person's gambling?				
Has your physical health been affected by the other person's gambling?				

Used with permission from N. Dowling, Taken from "The impacts of problem gambling on concerned significant others accessing web based counselling". Nicki A. Dowling, Simone N. Rodda, Dan I. Lubman, Alun C. Jackson. Addictive Behaviours 39 (2014) 1253-1257.

To be filled out by the interviewer

Client Name: a._____ b. __ **c.**_____
(First name) **(M.I.)** **(Last name)**

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0.1 CAMH

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1. **When was the last time** that you had **significant** problems with…

a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? 4 3 2 1 0

b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? 4 3 2 1 0

c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? 4 3 2 1 0

d. becoming very distressed and upset when something reminded you of the past? 4 3 2 1 0

e. thinking about ending your life or committing suicide? 4 3 2 1 0

f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts? 4 3 2 1 0

EDScr 2. **When was the last time** that you did the following things **two or more times**?

a. Lied or conned to get things you wanted or to avoid having to do something 4 3 2 1 0

b. Had a hard time paying attention at school, work, or home. 4 3 2 1 0

c. Had a hard time listening to instructions at school, work, or home. 4 3 2 1 0

d. Had a hard time waiting for your turn. 4 3 2 1 0

e. Were a bully or threatened other people. 4 3 2 1 0

f. Started physical fights with other people 4 3 2 1 0

g. Tried to win back your gambling losses by going back another day. 4 3 2 1 0

SDScr 3. **When was the last time** that…

a. you used alcohol or other drugs weekly or more often? 4 3 2 1 0

b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)? 4 3 2 1 0

c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? 4 3 2 1 0

d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events? 4 3 2 1 0

e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? 4 3 2 1 0

(Continued) After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a.	had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b.	took something from a store without paying for it?	4	3	2	1	0
c.	sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d.	drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e.	purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a.	missing meals or throwing up much of what you did eat to control your weight?	4	3	2	1	0
b.	eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	3	2	1	0
c.	being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	4	3	2	1	0
d.	thinking or feeling that people are watching you, following you, or out to get you?	4	3	2	1	0
e.	videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	0
f.	gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioural, or personal problems that you want treatment for or help with? (If yes, please describe below) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. _____

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only					
8. Site ID: _____ Site name v. _____					
9. Staff ID: _____ Staff initials v. _____					
10. Client ID: _____ Comment v. _____					
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered					
13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____					
15. Referral comments: v1. _____					
Scoring					
Screener	**Items**	**Past month (4)**	**Past 90 days (4, 3)**	**Past year (4, 3, 2)**	**Ever (4, 3, 2, 1)**
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				
Supplemental questions	AQ5a-f				

HÔTEL-DIEU GRACE HEALTHCARE

BED-BASED PROGRAM
MEDICAL CLEARANCE FORM
CENTRE FOR PROBLEM GAMBLING AND DIGITAL DEPENDENCY

Client: _____

D.O.B.: _____ (mm/dd/yyyy)

Healthcard #: _____

Version Code: _____

Date: _____ (mm/dd/yyyy)

Does patient have any communicable diseases? ☐ Yes ☐ No
If yes, please specify: _____

Is patient on any medication(s)? ☐ Yes ☐ No
If yes, please list below.

Medication	Dosage	Duration

Does patient have any allergies? ☐ Yes ☐ No
If yes, please specify: _____

Does this patient have any other pre-existing medical conditions that may inhibit their participation in this program? Please list all below.

_____

_____

Is this patient able to:
Sit in a chair for up to 2 hours? ☐ Yes ☐ No

Participate in moderate exercise? ☐ Yes ☐ No

Is this patient medically fit to attend the 3-day Bed-Based Program at HDGH Centre for Problem Gambling and Digital Dependency? ☐ Yes ☐ No

If patient is not cleared for participation in program, please give reason: _____

_____

_____

_____ _____
Physician Signature Physician Address

_____ (mm/dd/yyyy) _____
Date Physician Phone Number

Please fax this form to Centre for Problem Gambling And Digital Dependency 519-254-0093

HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

Centre for Problem Gambling and Digital Dependency – Family Retreat Weekend

PROGRAM INFORMATION GUIDELINES

1. Prescriptions need to come in their original bottle (not expired) or blister packages from the pharmacy. Homemade Dosett or pill organizers will not be permitted. All medications must be taken as prescribed and the amount taken by clients must be verified by staff prior to being ingested. All medications will be self-administered with the supervision of staff. If changes are made to your medications (new medications added, subtracted or adjusted) you are to ensure that staff is made aware of these changes at the time of your registration and/or throughout your time in the program. We would also prefer that you have your medications blister packed by your pharmacy if you take a lot of medications.
2. Over the counter (OTC) or non-prescribed medications/vitamins are permitted at CPGDD pending the medication arrives with you in its original container with dosage and dispensing instructions. We do not carry or provide any stock medication on site so please bring what you think you may need. Medications will not be shared.
3. Caffeine pills/drinks (energy drinks) are **not permitted.**
4. Stimulants or opiates that are non-prescribed are **not permitted.**
5. Clients must ensure that all medical and dental needs have been taken care of before attending the program.
6. Cell phones are not permitted to be used during the program. Cell phones will be turned into the Addictions Support Worker upon intake and returned to the client at discharge. Clients are permitted to use the landline phone on the CPGDD unit for all outgoing phone calls. It is <u>not</u> required that you purchase any calling cards to make long distance calls within Canada. Clients are permitted 30 minutes of phone time per day. This time is to be used all at once and cannot be split up. Please sign up for your preferred phone time on the sheet located near the phone on program. The time of your calls can fluctuate daily, however it cannot interfere with the program. **Clients are not to use pay phones in lobby or elsewhere.**
7. Food, laundry facilities and linens are provided. Please ensure that staff is aware of all diet restrictions before attending the program. Bring your own toiletries. Feel free to bring anything else that will make you feel more comfortable during your stay with us (e.g., pop, snacks, frozen meals, etc.), however, please be mindful not to bring an excessive amount.
8. Electric hair dryers, hair straighteners or curling irons are not permitted to be brought into the program (we have them here for you to use). Electric shavers are permitted. Personal pleasure devices are not permitted.
9. You will be sleeping in a private bedroom with an attached bathroom. A cabinet with a lock is also provided for your personal belongings.
10. You will be encouraged to exercise daily (i.e. walking). Bring suitable work out clothing and running shoes.
11. No gambling, gaming and internet paraphernalia is allowed, including and not limited to cards, lottery, scratch, or Proline tickets. Any of these items will be confiscated and disposed of if brought to the program. Luggage, bags, purses, etc. will be inspected by staff upon arrival.
12. Television, magazines, newspapers, radio, videogames, internet access, MP3 players and all electronic devices are all prohibited during your stay here. You are welcome to bring books/novels with you.

13. No drug or alcohol use is permitted while in program. We request that you not come to the program under the influence of any substance (drugs or alcohol).
14. Weapons are not permitted to be brought to CPGDD.
15. Dress is to be appropriate, clean, and free of any sports teams or gambling/gaming/internet logos/advertisements. **All clothing will be placed in a dryer on high heat upon arrival** (this is to prevent bed bugs). Please do not bring any clothing that you would not like to be placed in a dryer (jackets included).
16. Casual shoes are appropriate for the daily program. Footwear is required at all times during program except in your individual room. No bedroom slippers are to be worn outside of your room during the program sessions.
17. It is strongly advised that you do not bring large amounts of cash, jewelry, or other valuable items. A cabinet with a lock is provided in each bedroom for you to lock up any personal items).
18. Break times and permission to leave CPGDD will be discussed once on program.
19. As per a scent-free policy within Hotel-Dieu Grace Healthcare, the use of perfumes, colognes, body sprays, etc. are prohibited.
20. Bring your valid Ontario Health Insurance Plan (OHIP) Card.
21. If you get lost or require any assistance upon your arrival, **please call 519-257-5111 Extension 76990** to reach staff in the Bed-based Treatment Program. Clients will be discharged from the program at 12:00pm on the Monday.
22. Smoking on the premises is prohibited; smoking off site is permitted.
23. Clients are encouraged to arrive between 8:00am and 11:00am. Those who arrive later than 12:00pm **will not** be admitted to program (please call staff at the above noted number and extension should you get stuck during your travels due to inclement weather/unforeseen delays).
25. **** Note: If you have been ill (coughing, fever symptoms, etc.) in the last 48 hours prior to your cycle starting, please contact us for further information. If you become unwell during program, you will be asked to wear a mask and your time while on program will be re-evaluated and assessed further. ****

What we are doing to keep clients safe...

- Medical grade masks are provided to clients for use if preferred
- Hand sanitizer is available in all rooms and hallways
- A handwashing station is available on the unit for anyone to use
- Sinks are in each client's bedroom/bathroom area for personal use
- Bedrooms are private and thus easy to self-isolate if preferred/needed
- Cleaning of commonly touched surfaces will be performed on a frequent basis

Please check the below boxes to indicate understanding.

☐ **I agree that I have read the above guidelines and commit to following them while at CPGDD.**

☐ **I am aware that should I choose to leave CPGDD or I am asked to leave CPGDD that I am responsible for making arrangements to return home. HDGH will not be held liable for any costs incurred as a result of a client choosing to leave or being asked to leave program.**

_____ _____

Client Signature Date