Program Application Package

Healing and recovery happen here. As the only residential eating disorder recovery center in Saskatchewan, BridgePoint fulfills a unique niche as we provide a holistic approach to eating disorder recovery.

Dedicated to people 16 years and older with disordered eating, or an official eating disorder diagnosis, we offer group-based residential programming that is integrative, responsive, and collaborative. Programming includes psychoeducation and process groups, intensive experiential learning and teaching sessions within a group model, individual discussions and processing of personal issues. Individuals are encouraged to progress at their own rate toward their personal or optimal level of wellness.

Attending a retreat is the first phase of programming. It is a chance to learn tools and coping strategies, make connections with others struggling with similar issues and start the recovery process. Available programming dates can be found on our website. Co-ed programming is scheduled based on demand.

Our current complement of sequential programming options includes:

- **Retreats** (offered 8-10 times annually) – *Prerequisites: Submit Form A; self-referral or professional referral*
- **Module 1** (offered 3 times annually) – *Prerequisites: Completion of a Retreat; Submit Forms A, B, C*
- **Module 2** (offered annually) – *Prerequisites: Completion of Module 1; Submit Forms A, B, C*
- **Module 3** (offered sporadically dependent on funding)– *Prerequisites will vary dependent on program offered; typically include completion of at least Module 1, with preference to those who have recently completed all available programming, using their tools, highly motivated and actively pursuing recovery.*
- **Youth Program** *Prerequisites include Form A (Youth), ages 12-16, and may include parents and caregivers.*
- **Co-ed Programming is offered based on demand.**
- **New Virtual Programs**

The BridgePoint model is holistic in approach and not a medical model. Our multi-disciplinary team is comprised of peer, paraprofessional and professional support with diverse backgrounds, education and experience. We work in partnership with the Saskatchewan Health Authority and include community mental health nurses onsite during admission and intake process. Participants are required to remain medically stable prior to attending and throughout the program must be medically and psychiatrically stable for admission and to remain in the program. Health centers in Rosetown and Outlook are 25 minutes away from the center.

Our program uses multi-modalities through a strengths-based and non-diet approach lenses, including DBT (emotional and social), CBT (thoughts), Family Inclusivity, EFFT, ACT, Solution Focused, Narrative (story), Brain Research & Neuroplasticity, Creative Expressions, Yoga & Movement, Nutrition, Brené Brown and Equine Assisted Learning. We integrate breath work, guided visualizations, and mindfulness practices.

Self–responsibility is encouraged and supported in all programming. In each step of the programming, participants will stay onsite in community. We generally accommodate up to 8 participants at a time. The smaller group number allows for diversity and connection as a group.

What to expect

Our team has diverse and integrated strengths, talents and resources to support your needs. The residential nature of the program means that there are always opportunities for reflection, learning and growth. Exploration and sharing takes place within a group setting during the module. Eating disorders thrive on secrecy and isolation, so the experience of living in community is profound as it offers a sense of belonging and inclusion and allows for mutual support. Struggling with an eating disorder can be a very lonely, painful existence. We understand this. Most rooms are double occupancy with limited single rooms.

Arrival Times & Program Schedule

The doors will open at 3pm for all programs, unless otherwise advised. If you arrive prior to this time, you will be able to wait in the front lobby until the intake process begins. It is important to arrive on time for intake. Programs run from 9am until 9pm with a full day of group learning, community meals and personal opportunity time.

Dining & Kitchen Info

Dining together in community is an important part of the program. Participants will also serve an integral part in the preparation and clean-up of meals. Instead of food policing and focusing on meal plans, we focus on why individuals may be using behaviours, rather than the behaviours themselves.

BridgePoint provides three meals and snacks as part of the program. The food services team provides homemade baking, soups, breakfast and noon food prep, and the evening meal prep. We try our best to provide participants nourishing and nutritious menu choices.

Please let us know as far in advance of your program if you have food sensitivities or allergies. If your allergies are severe enough to require you to carry an epi pen, please inform us as well. We do our best to accommodate special diets, but we cannot guarantee that all requests can be offered. Vegetarian choices are part of a rotation of chicken, fish, beef and pork, some which would be suitable for vegans.

Our kitchen is not equipped to provide Kosher/Halal meals and cannot provide the level of Gluten Free foods that someone with Celiac disease would require.

There is a fridge onsite for participant use. We ask you not to binge on community food, so please bring your own binge food if you think you will require it.

Our Facilities

We are located in the former Milden Hospital in the quaint town of Milden in central Saskatchewan. Over the last couple of decades, much care and attention has been taken to modernize the facility and to make it a safe and comfortable retreat like setting. The tranquility and simplicity of being in rural Saskatchewan eliminates the distractions of day-to-day life and provides space to focus on discovery and recovery.

Our address is: 744 Saskatchewan Avenue in Milden, Saskatchewan (in between Rosetown and Outlook along Highway 15).

You are welcome to park on either side of the street in front of the center and come in the main doors. Please do not park in front of the church.

There are basic laundry facilities on site for you to use free of charge. A set of bedding, pillows, towels and a laundry basket are available for each participant to use during programming.

Bridgepoint is a scent sensitive and peanut free facility.
*Thank you for **not** bringing peanuts or peanut products, scented lotions, shampoos, body wash, soap, perfumes, hairsprays, essential oils or other scented products.*
Please refrain from all mind altering substances prior to admission. BridgePoint is not a detox facility.

What to Bring

- Go cup and/or water bottle
- A meaningful inspiration to share at Tea Time (poems, stories, pictures, music, etc)
- Medication (prescription & non-prescription medications are to be in original bottles/packages or blister packs). Please make sure that prescriptions are labeled with correct dosages and you have adequate supply for the entire program. If you suffer from severe allergic reactions, please bring your Epi-pens.
- Toiletries – we are a "**SCENT SENSITIVE**" facility. Please ensure all shampoo, lotion, body wash, etc. are scent free.
- Any specialty foods that you require – excluding peanuts/peanut butter as we are a "**PEANUT FREE**" facility
- Comfy clothes (layers are recommended); bring appropriate outdoor clothing for season
- Quilt or polar fleece blanket and anything that would give you comfort while you are here
- Cell phones and electronics are welcome here but are not used during group or meal time. There is no public WIFI.
- Call the office if you require approval to bring medical marijuana. It needs to be approved in advance with proper support from your physician and confirmation of license and prescription.
- If you are attending a module or follow-up programming, please bring back all of the above plus any of your journals and sketchbooks.
- Mobility devices (walkers, bath or shower room aids)

Application Process

BridgePoint can support you during the application process. Our ***Recovery Support Line*** is open from Tuesday to Thursday (1pm-9pm) for pre and post programming support (when not in scheduled programming).

As space for each program is limited and the demand for the program is continuing to increase, we encourage you to contact us with your interest in attending a program. Once you apply for a program, you will indicate your preferred program dates. Program confirmations may be based on participant stability, referrals and coordination with SHA, availability of beds, prior admissions, previous attendance, etc.

Following our verification that all the necessary components of the referral/application have been satisfied and all forms completed and received, BridgePoint will contact the participant to confirm they are registered for participation in the program. **A space is not confirmed without verbal or email confirmation from BridgePoint.** Participants are required to be medically and psychiatrically stable in order to be admitted into and remain in the program.

Upon receiving a completed application package, a team member will contact you to clarify any questions and to advise on the next available program date.

If you have any other questions or concerns please contact us:

BridgePoint Center Inc.
Box 190, Milden, Saskatchewan S0L 2L0 Phone: 306-935-2240 • Fax: 306-935-2241
Email: bridgepoint@sasktel.net Website: www.bridgepointcenter.ca

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.

BRIDGEPOINT
CENTER FOR EATING DISORDERS

PART B
completed by Counsellor

CONFIDENTIAL INFORMATION – COUNSELLOR REFERRAL

BridgePoint Center is a non-profit provincially approved facility that works in partnership with the Saskatchewan Health Authority. We are a part of the continuum of services offered in Saskatchewan for the treatment of eating disorders. Our intention is to create a working relationship to provide continuity of care. As such, we request that you provide the following information as part of your referral. You may be contacted should there be further information required. All information will be held in confidence. Our mutual client will be asked to sign a release of information to facilitate communication with both physician and counsellor as part of creating a home plan.

If you are referring on behalf of a client, please ensure that the client has also completed and submit Part A of the application.

Client Name: _____

How Long have you been in a therapeutic relationship with this client? _____

Are you available for ongoing support after your client completes the Module? ◯ **Yes** ◯ **No** If not, why? _____

_____

Please describe the issues you and your client are currently addressing:

_____

_____

_____

_____

Please share any of your client's pertinent history (including any trauma, abuse, addiction or substance use).

_____

_____

_____

Do you support your client's choice to attend BridgePoint Center at this time? Do you have any concerns or information that we should be aware of?

_____

_____

_____

_____

Referring Agency

Name: _____ **Email**: _____

Clinic Name/Address:_____

Phone: _____ **Fax**: _____

For admission to BridgePoint, participants must be psychiatrically and medically stable.

Please review and check:

◯ I am available to participate in a 20 minute home plan conference call with BridgePoint and my client at the end of program; scheduled one day prior to discharge. I am available at the following times: _____ _____ or _____ at the following phone number: _____.

We will contact you via email to confirm appointment times.

◯ I am not available to participate in a conference call but would like to receive follow-up documentation.

◯ Supplemental reporting or information to this referral.

Referral Signature: _____ Date: _____

Please return: Admissions, BridgePoint Center Fax: (306) 935-2241 Email: bridgepoint@sasktel.net Phone: (306) 935-2240

www.bridgepointcenter.ca

BRIDGEPOINT
CENTER FOR EATING DISORDERS

PART C
completed by Physician

CONFIDENTIAL INFORMATION – MEDICAL STATUS & STABILITY REFERRAL FORM

If you are referring on behalf of a client, please sure that the client has also completed and submit Part A of the application.

Client Name: _____ **PHN**: _____

Age: _____ **Height:** _____ **Weight:** ____ **BMI:** _____ **Blood Pressure:** ____ **Pulse:**_____ **LMP:** _____ **TEMP:** ____

Provide Eating Disorder Behaviours, Diagnosis as well as other concurrent diagnoses:

_____

_____

_____

Pertinent Past Medical History:

_____

_____

_____

Has the client been medically unstable in last 6 months? ◯ Yes ◯ No **Provide Details:**

_____

Is the client currently medically stable? ◯ Yes ◯ No **If yes, for how long**? _____

Indicate any pertinent abnormalities or stability concerns:

_____

_____

Date of last physical:	Concerns:			
Changes in weight during the past year	◯ Gain	◯ Loss	◯ Stable	How Much:
At risk of refeeding syndrome	◯ No	◯ Yes		
Recent medication Changes	◯ No	◯ Yes	◯ Compliance concerns:	
Known substance usage/abuse/addiction	◯ No	◯ Yes	Specify:	*** CANNOT DETOX AT BRIDGEPOINT**
Medical marijuana prescription	◯ No	◯ Yes	Please attach.	
Known self-harm behaviours	◯ No	◯ Yes	◯ Past	Specify:
Seizure in last 6 months	◯ No	◯ Yes	Specify cause/Treatment:	
Diabetic	◯ No	◯ Yes	Specify Type/Treatment:	
Pregnant	◯ No	◯ Yes	# weeks/concerns:	
Sleep Apnea	◯ No	◯ Yes		
Mobility concerns/mobility devices	◯ No	◯ Yes	Participant must be able to attend to their own self care.	
Medically diagnosed allergies	◯ No	◯ Yes	Reaction:	

Pre-Admission Lab Work 2 weeks prior to admission: **PLEASE FAX TO BRIDGEPOINT CENTER (306) 935-2241**

*Bloodwork is to be reviewed by physician as part of determining stability required for admission. If physical or labs are abnormal, please indicate plan for follow-up, treatment or attach **additional notes.***

- **Routine Urinalysis**
- **Electrolytes**
- **Creatinine + eGFR**
- **Urea**
- **HbA1c**
- **Calcium**
- **Iron Levels and TIBC**
- **THYSA**
- **Liver Functions**
- **Protein Levels**
- **B12**
- **ECG (if applicable)**

Weekly bloodwork is not typically available during programming unless discussed and planned prior to programming.

Check here:

◯ I understand BridgePoint Center is **not** a medical facility and consider my patient's current medical stability status suitable for admission for residential eating disorder treatment**. I will update BridgePoint on any changes in stability prior to admission**.

Referring Agency: ◯ GP/Family Doctor ◯ Nurse Practitioner ◯ Other _____

Physician Name *(please print)*: _____ **Clinic:** _____

Phone: _____ **Fax:** _____

Referral Signature: _____ **Date:** _____

Please return: Admissions, BridgePoint Center Fax: (306) 935-2241 Email: bridgepoint@sasktel.net Phone: (306) 935-2240

WAIVERS & UNCONDITIONAL PROGRAM RELEASES

The following consents will expire only upon written notification advising BridgePoint "consent is withdrawn".

I, *(name)* _____ , of *(city/town)*_____, of *(province)* _____ , Canada, 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 Milden, Saskatchewan.

I RECOGNIZE that the reason I am attending BridgePoint is due to my eating disorder, which by its very nature threatens my life. I therefore intend to relinquish my legal rights to the extent that I intend to fully assume the risks for any injuries or physical harm that may come to me for the duration of my stay at BridgePoint.

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 residential programming by BridgePoint. I am signing this document of my own free will.

CONSENT NO SELF-HARM CONTRACT

I agree that should I experience feelings of wanting to physically hurt myself during my stay at BridgePoint, I will approach a BridgePoint team member for support prior to carrying out such actions. I understand that the BridgePoint team, in consultation with me, will implement measures to ensure I remain physically safe until such time that I am verbally and physically able to demonstrate no further thoughts of self-harm. Such safety measures may include:

- Allowing staff to monitor me until such time as my feelings and behaviors of self-harm are able to be controlled by me;
- Transfer to hospital via emergency medical services if my needs, as assessed by BridgePoint team members, are determined to be too acute to manage at BridgePoint. This contract will remain valid during my entire stay(s) at BridgePoint.

CONSENT PROGRAM PARTICIPATION

I consent to participate in all programming offered during my residential stay(s) at BridgePoint. In giving my consent, I agree to abide by and follow all walls and boundaries governing the operation of the program. I also agree to participate in all program activities in facilitating my recovery process to the best of my ability. I am aware that BridgePoint is not responsible for loss or damage sustained to any personal property I bring with me to the program.

ADULT CONSENT FOR MEDICAL TREATMENT

BridgePoint Center Inc. (herein after referred to as "BridgePoint") in Milden, Saskatchewan, utilizes physician, hospital and ambulance services in Outlook and Rosetown. Transportation to larger centers occurs only when the local community cannot adequately meet services, or when specifically requested by the individual receiving treatment.

Individuals attending BridgePoint Programs are fully responsible for the cost of their personal medications whether covered under insurance plans or not.

I give consent to BridgePoint to utilize their community physician to provide for my routine health care needs while attending BridgePoint programs. In the event I require emergency medical treatment:

Please choose one of the following & initial:

◯ I give consent to be treated at either the Outlook or Rosetown Hospital. ***I am aware that I am responsible for all financial costs incurred for ambulance service and/ or other approved transportation.**

◯ I give consent to only being stabilized at Outlook or Rosetown Hospital, and then transferred as soon as possible to the hospital of my choice for further treatment. ***I am aware that I am responsible for all financial costs incurred for ambulance service and/or other approved transportation.**

◯ When Outlook or Rosetown hospitals are unable to accommodate our needs, I give consent to treatment at other health facilities in the SHA as discussed on a case by case basis with BridgePoint and Mental Health and Addictions Services.

Initial: _____

SELF-MEDICATION PROGRAM PARTICIPANT CONSENT FORM FOR ADULTS

I acknowledge that BridgePoint Center Inc. (hereinafter referred to as "BridgePoint") utilizes a self-medication program and will utilize the program during my stay at BridgePoint.

I voluntarily agree to participate, and to the best of my ability will follow the self-medication program instructions given to me by the nursing staff. I understand that the self-medication program may change to accommodate my individual needs.

I voluntarily surrender all medication prescribed, over-the-counter, and otherwise for the duration of my stay at BridgePoint.

I have voluntarily provided a complete and accurate description of my medication/drug use.

I understand that failure to comply with the self-medication program could result in harm to self and jeopardize my stay at BridgePoint.

I agree that BridgePoint will not be held legally liable for the medications I take under the self-medication program.

I will assume complete responsibility for my own medications and will report to team any problems that may arise throughout my stay. If I am unable to manage my medications I will alert BridgePoint team members.

Initial: _____

SELF-MEDICATION PROGRAM POLICY ADULT

- Upon admission to any of BridgePoint's Programs, Participants will give consent in written form to participate in the Self Medication Program. Whenever possible this program will be designed to meet the Participant's specific needs.
- Upon admission, the Nurse or team member will review the medications with the Participant. Participant will identify medications, reason for taking the medication(s), dose, time of day taken, duration taken, effectiveness, and any noted side effects.
- Each Participant will bring a sufficient supply of currently prescribed medication(s) as well as any over-the-counter medication(s) needed during their stay at BridgePoint. If there is any discrepancy between Participant stated dose and prescribed dose, the Participant's home doctor will be contacted as soon as possible. His decision will be documented in the Participant's chart, and will be acknowledged as the current prescription.
- All medication will be surrendered to the BridgePoint Team. All medications are kept in a locked room. Participants will have access to their individual medications via a BridgePoint Team Member.
- A weekly dosette will be provided for each Participant. The Nursing Associate(s) will supervise the Participant in filling or refilling the dosette.
- At all times Participants will self-administer medication, in the med room, in the presence of a team member. Following each self-administration, the Participant will document self-administration by initialing on the provided form.
- Team Members will check documentation at 2300 hours to determine Participant's medication compliance. Noncompliance will be documented in the Participant's progress notes.
- Medication noncompliance will result in the Participant's stay at BridgePoint being reviewed by the Team.
- Should a Participant require medical intervention from a local physician, any new medications prescribed will be reported and immediately surrendered to a BridgePoint Team Member who, if not a nurse, will ensure that the Nursing Associate is advised. The Nursing Associate will document the new medication in the charts, progress notes and inter-agency report.
- Under no circumstances will Participants provide any medication of any type or form to other Participants.
- Any sudden decrease or discontinuation in laxative use is potentially lethal. Seek BridgePoint Team assistance in determining medically safe ways to alter laxative dependency.

◯ **I acknowledge BridgePoint is a Peanut Free & Scent Aware Facility.** ***Initial:*** _____

IN WITNESS WHEREOF I have executed these releases at:

(city/town) _____ (Month/Day/Year) _____

_____ _____

Signature of Participant *Date of Participant Signature*

_____ _____

Signature of Witness *Date of Witness Signature*

BRIDGEPOINT CENTER RESIDENTIAL COMMITMENT

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

Boundaries

1. I will participate in all program activities and groups, including communal meal preparation and housekeeping activities.
2. I am responsible for caring for my own property and living area space while at BridgePoint.
3. I will be present in the dining room for at least 15 minutes during meals and honor any dietary agreements developed with the BridgePoint team.
4. I will store all food and beverages, in the identified fridge, in the kitchen. I will label and identify all personal food and beverages. All food and drinks must be stored in the participant fridge or shelving unit and not in bedrooms.
5. I will eat my meals in the dining room. When I consume drinks and snacks in the common areas, I will return all my dishes to the kitchen and rinse them. No food will be stored or consumed in bedrooms.
6. I will ask team members to support and assist me in exploring alternative ways of coping, rather than bingeing, purging, restricting, hoarding or eating compulsively. If I choose to binge, I will purchase my own binge food. I will not binge on community food
7. Any sudden decrease or discontinuation in laxative use is potentially lethal. I will seek BridgePoint team assistance in determining medically safe ways to alter laxative dependency.
8. I will practice courteous and responsible behavior. I will demonstrate adequate impulse control.
9. If I don't have a cell phone, I will give friends and family the (306) 935-2242 telephone number in order to call me. I will make long distance calls by using a calling card, calling collect or own personal cell phone.
10. I will not use my cell phone during any group activities, programming or at mealtime. All cell phones will be stored in the baskets provided or in my room.
11. During a retreat weekend if I choose to leave the program prior to its completion, I agree to consult team members to arrange for my safe departure. For the safety of participants, team may not allow for departure during inclement weather or during non-daylight hours.
12. During the Module should I choose to leave the program, I agree to remain at BridgePoint for 24 hours from the time I inform team members of my decision. I also agree to participate in a closure conference call with my counselor and BridgePoint team members prior to my departure.
13. A First aid kit is publically accessible in the kitchen. BridgePoint is equipped with Carbon Monoxide and fire detectors in each wing. Familiarize yourself with the closest exits in the building. In the event of a fire, Team will direct you to meet in the parking lot in front of the residence on the West side of the BridgePoint building.

Walls

Walls provide a <u>firm</u> 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. *("Participants"* is all encompassing and includes team, family members and friends).

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 **<u>zero tolerance</u>** 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. BridgePoint is a smoke free facility. If I smoke or vape, I will do so only in the area provided **<u>outside the north wing exit</u>**. I will not burn incense, candles or other open flame products in my room.

5. I will not bring or consume alcohol, use drugs (including marijuana *unless previously approved as medically necessary*), or other mind altering substances while attending BridgePoint.

6. I have **sufficient medication to last the duration of the program** and will store all my prescription and non-prescription drugs, car keys, and sharps (i.e.: razors/ knives) in the medication room. **I will bring all medications in <u>original</u> containers with the current prescription attached or in blister packs.** I will adhere to the self-medication policy. I will not share prescription or non-prescription medication.

7. When leaving the Center for any reason I will sign out and sign in upon my return. This is available to me during daylight hours only. I will have a "buddy" with me whenever not in sight of the building. **I will remain within the town limits.**

8. I will respect all BridgePoint belongings and property, and will leave my room as clean as I found it with all the provided amenities. BridgePoint will not tolerate stealing. I will make financial restitution if I deliberately damage or destroy BridgePoint property. I will make financial restitution if the condition of my room upon leaving requires additional cleaning or repair (for that which is beyond normal use). There will be a room check at the end of each program.

9. The BridgePoint team meets regularly and shares, with each other, the content from conversations with participants, parents/guardians, and family & friends. Our intention is to have consistent information and understanding, amongst the team, for effective program delivery. All information is held in strict confidence except in instances where we are bound by law to report.

10. In order to remain at BridgePoint, participants must remain medically and psychiatrically stable during the entire program. I will keep myself safe while at BridgePoint. I will reach out to Team should I feel like I am not able to keep myself safe. Team will engage outside resources as necessary in ensuring the safety of participants. Participants who check themselves out of a medical facility against the advice of medical professionals will not be returned to BridgePoint, and will have to arrange safe transportation home. Participants are responsible for any costs incurred for safe transportation.

I understand the BridgePoint Center "Residential 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_____

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.

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