St. Joseph's Care Group

Referral to Adult Addictions Services

Sister Margaret Smith Centre

301 Lillie St. N. Thunder Bay, ON P7C 0A6
Tel: 807-684-5100

- ☐ Live-In Addiction Treatment
- ☐ Outpatient Addiction Services
- ☐ Addiction Day Treatment
- ☐ Gambling and Behavioural Addictions

Sister Margaret Smith Centre requires referrals to be completed by a counsellor and accompanied by an assessment for live-in treatment referrals.

Crossroads Centre

500 Oliver Rd. Thunder Bay, ON P7B 2H1
Tel: 807-622-2730

- ☐ Pre-Addiction Treatment
- ☐ Post-Addiction Treatment

Send completed referrals to:

Mail: 301 Lillie St. N.
Thunder Bay, ON P7C 0A6
Fax: 807.622.1779
Email: sjcg.smsccrossroadsintake@tbh.net

Lodge on Dawson

1460 Dawson Rd. Thunder Bay, ON P7G 1H8
Tel: 807-625-5409

- ☐ Transitional Housing Program
- ☐ Stabilization

Lodge on Dawson Transitional Housing Program requires a Service Prioritization Decision Assistance Tool (SPADAT) and an Application for Rent-Geared-To-Income Housing Assistance to be completed and submitted to Thunder Bay District Social Services Administration Board (TBDSSAB).

Send completed referrals to:

Mail: 1460 Dawson Rd.
Thunder Bay, ON P7G 1H8
Fax: 807.625-6521
Email: sjcg.LODReferrals@tbh.net

THUNDER BAY INTEGRATED ADDICTION AND MENTAL HEALTH SERVICES
CONSENT TO OBTAIN / RELEASE INFORMATION

The protection of your privacy and the delivery of high quality care is our priority. In order to best serve you, a group of service providers, all committed to the protection of your privacy, are working together to support your decisions regarding your care. With your permission, we will share information with each other and with other agencies to support you in developing a plan of care that is designed to support your choices and decisions.

The following agencies are part of a service system which is designed to support you in reaching your personal goals.

Thunder Bay Counselling Addiction Services, Thunder Bay, ON	☐ _____	St. Joseph's Care Group Crossroads Centre Thunder Bay, ON	☐ _____
St. Joseph's Care Group Addiction & Mental Health Services Thunder Bay, ON	☐ _____	Dilico Anishinabek Family Centre Mental Health and Addictions Services Thunder Bay, ON	☐ _____
Alpha Court Community Mental Health & Addiction Services, Thunder Bay, ON	☐ _____		

If you are in agreement for the above named agencies and related programs to share assessment, treatment and case management information, please indicate your authorization by **initialing beside each relevant agency**.

In addition, there may be cause to share your personal health information with other care providers and agencies to support you in meeting your personal goals. If you are in agreement for the agencies listed below to obtain/release information with the authorized agencies in Thunder Bay Integrated Addiction and Mental Health Services please sign beside each agency indicating your authorization.

Consent to release/request information from the persons/agencies below:	Date	Signature
1. Electronic Medical Record (EMR) TBRHSC & SJCG	_____	_____
2. Consent to email referral package between agencies	_____	_____
3._____	_____	_____
4._____	_____	_____

Having read and understood this form, I hereby authorize the identified agencies of Thunder Bay Integrated Addiction and Mental Health Services to Release/Request Information to/from each other and to/from the persons/agencies listed above. I also understand that I can withdraw my consent in writing at any time and that I can restrict the nature and type of information shared. This consent is considered valid for a period of six (6) months from the date of signature when it will be reviewed and renewed as required.

_____

Name (Please Print) D.O.B. (dd/mm/yyyy) Signature

_____ _____

Reviewed and Witnessed By Date

Substitute decision maker (Please Print)_____

Signature:_____ Date:_____ Relationship:_____

THUNDER BAY ADDICTION AND MENTAL HEALTH SERVICES GUIDELINES FOR COMPLETING FORM

- Clinician / Case Manager will review the Consent to Obtain/Release Information with the client and address any questions/concerns prior to obtaining a signature
- Clinician / Case Manager will review the Consent to Service prior to obtaining client signature
- Copy of the Consent to Service and Consent to Obtain/Release Information will be filed on the clients' record
- The receiving agency conducting the initial intake will also provide a copy of their agency's privacy statement

CLIENT INFORMATION FORM	REFERENT INFORMATION
FIRST NAME: _____ **MIDDLE NAME:** _____	**DATE OF REFERRAL:** _____ **REFERRING AGENCY:** _____
LAST NAME: _____ **LAST NAME AT BIRTH:** _____ **EMAIL ADDRESS:** _____	
DOB:DD/MM/YEAR _____ **AGE:** _____ **GENDER:** _____	**NAME OF REFERENT:** _____ **EMAIL:** _____
HEALTH CARD # : **PROVINCE:** ON ☐ **NO FIXED ADDRESS** ☑ **MAILING ADDRESS:** **STREET:** _____ **CITY:** _____ **PROVINCE:** ON **POSTAL CODE:** _____	**AGENCY ADDRESS:** _____ **POSTAL CODE:** _____ **PHONE:** _____ **FAX#:** _____
HOME PHONE # : _____ **OTHER PHONE #:** _____ **CALL ALLOWED:** ☐ YES ☐ NO **MESSAGE ALLOWED:** ☐ YES ☐ NO **PREFERED LANGUAGE:** ☐ English ☐ French ☐ Other _____	**CLIENT TYPE – PLEASE CHECKMARK** ☐ Client- Alcohol/Drug ☐ Client- Alcohol/Drug/Gambling ☐ Client- Gambling ☐ Family member of Alcohol/Drug Client ☐ Family member of Alcohol/Drug/Gambling Client
EMERGENCY **CONTACT:** _____ **RELATIONSHIP:** _____ **PHONE #:** _____	**ETHNICITY- ETHNIC OR CULTURAL IDENTITY:** PRIMARY _____ STATUS # _____ BAND _____

PLEASE CHECKMARK IN EACH SECTION THAT BEST FITS:

1. 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 _____

2. LEGAL STATUS:

- ☐ No problem
- ☐ Awaiting trial\sentencing
- ☐ On probation- Start date: _____ DD-MM-YYYY) End date:_____ (DD-MM-YYYY)
- ☐ On parole - Start date: _____ (DD-MM-YYYY) End date:_____ (DD-MM-YYYY)
- ☐ Incarcerated
- ☐ Other _____

3. RELATIONSHIP STATUS:

- ☐ Married/partnered/common-law
- ☐ Spouses Name: _____
- ☐ Single (never married)
- ☐ Widow or widower
- ☐ Separated or divorced

4. EMPLOYMENT STATUS:

- ☐ Employed full-time (includes self-employment)
- ☐ Employed part-time
- ☐ Unemployed (looking for work)
- ☐ Student\ retraining
- ☐ Program: _____
- ☐ Disabled (not working)
- ☐ Not in labour force
- ☐ Retired

5. HIGHEST LEVEL OF EDUCATION:

- ☐ No formal schooling
- ☐ Some primary school
- ☐ Primary school
- ☐ Some high school
- ☐ Completed high school
- ☐ Some college
- ☐ Completed college
- ☐ Some university
- ☐ University degree

6. INCOME SOURCE:

- ☐ Disability insurance (WSIB)
- ☐ Employment
- ☐ Employment insurance
- ☐ Family Support
- ☐ None
- ☐ ODSP
- ☐ Ontario Works
- ☐ Other Insurance
  Retirement
- ☐ Other _____

7. PARENTING (CUSTOM FIELD)

- ☐ Yes, with 1 or more child aged 0-6 years
- ☐ Yes, with no children aged 0-6 years
- ☐ Children in care of others
- ☐ No children

SUBSTANCE USE & GAMBLING HISTORY

PRESENTING PROBLEM SUBSTANCES:

	SUBSTANCE USED	FREQUENCY IN LAST 30 DAYS- CHECKMARK ONE
MAJOR SUBSTANCE		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly ☐ Daily ☐ Binge Age of 1st use: ☐ Age regular use began: ☐
1ST OTHER SUBSTANCE		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly ☐ Daily ☐ Binge Age of 1st use: ☐ Age regular use began: ☐
2ND OTHER SUBSTANCE		☐ Did not use ☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly ☐ Daily ☐ Binge Age of 1st use: ☐ Age regular use began: ☐

OTHER SUBSTANCES USED IN PAST 12 MONTHS: (checkmark all the ones that apply) CHECK ALL UNCHECK ALL

- ☐ Alcohol
- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Cannabis
- ☐ Cocaine
- ☐ Crack
- ☐ Ecstasy
- ☐ Glue /Inhalants
- ☐ Hallucinogens
- ☐ Heroin\ Opium
- ☐ Methamphetamines (Crystal Meth)
- ☐ Other Psychoactive drugs
- ☐ Over-the-counter codeine products
- ☐ Prescription Opioids
- ☐ Steroids
- ☐ Tobacco
- ☐ Unknown
- ☐ None

GAMBLING ACTIVITIES ENGAGED IN THE PAST 12 MONTHS:

- ☐ Bingo - live/TV/radio
- ☐ Slot machines
- ☐ VLT's/ other gaming machines
- ☐ Casino- Card/Table Games
- ☐ Non-Casino Card/Table Games
- ☐ Horse races-live/off-track
- ☐ Sports betting (including Pro Line)
- ☐ Lottery tickets
- ☐ Instant win/scratch tickets (i.e. break open, pull tab, Nevada strips)
- ☐ Internet Gambling
- ☐ Gambling with Stocks/Options/Commodities/Real estate
- ☐ Betting on games of skill i.e. pool, pitching pennies
- ☐ Betting on the outcome of events
- ☐ Other _____
- ☐ None
- ☐ Unknown

IS GAMBLING IDENTIFIED AS A PROBLEM? ☐ **YES** ☐ **NO**

HEALTH STATUS/PROBLEMS

Visual impairment: **YES** ☐ **NO** ☐

Hearing impairment: **YES** ☐ **NO** ☐

Mobility/ physical impairment: **YES** ☐ **NO** ☐

Pregnant: **YES** ☐ **NO** ☐ **UNSURE** ☐

Non-medical intravenous drug use:
- ☐ Never injected
- ☐ Injected prior to one year
- ☐ Injected in last 12 months

Reason for most recent hospitalization: _____ Date: _____

Diagnosed with a mental health problem by a mental health professional:

-within the past 12 months- **YES** ☐ **NO** ☐

-within lifetime- **YES** ☐ **NO** ☐

-most recent diagnosis- _____

Hospitalized for a mental health problem?

-within the past 12 months- **YES** ☐ **NO** ☐

-within lifetime- **YES** ☐ **NO** ☐

Received counselling/support/treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

-currently- **YES** ☐ **NO** ☐

-within the past 12 months- **YES** ☐ **NO** ☐

-within lifetime- **YES** ☐ **NO** ☐

-name of current service provider: _____

-contact information for service provider: _____

HEALTH CONDITIONS

Please check all that apply:

☐ Allergies

Environmental specify

Food specify

Does your allergy require an Epi-Pen?

Yes ☐ No ☐

☐ Blood pressure problems
☐ Cancer
☐ Chronic pain
☐ Diabetes
☐ Eating disorders (anorexia, bulimia,over
☐ eating) HIV/AIDS
☐ Heart disease
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ History of head Injuries/concussion
☐ History of seizures/epilepsy
☐ Jaundice
☐ Kidney disease
☐ Lice/scabies
☐ Liver diseases
☐ Menstrual/menopausal difficulties
☐ Pancreatitis
☐ Respiratory
☐ STD (syphilis, gonorrhea, chlamydia, Herpes)
☐ Stomach/gastrointestinal problems
☐ Thyroid problems
☐ Tuberculosis

Provider of Primary Health care (doctor, nurse practitioner, health clinic): _____

Contact information for provider of health care: _____

PRESCRIBED DRUGS

On Methadone or Suboxone: **YES** ☐ **NO** ☐ Prescriber: _____

Prescribed Drug	Prescriber & Phone #	Prescription Details

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING HEALTH STATUS:

REFERRAL INFORMATION:

1. What circumstances have made the client request treatment at this time?

2. What supports are you providing? How long have you been working with this client? Is therapy/counseling on going?

3. What supports does the client have access to in the community? What supports/services has the client accessed to date? (If the client has not accessed services please explain why)

TREATMENT HISTORY

1. Has the client previously tried to quit or cut down on their substance use or gambling?

No ☐ Yes ☐ How many times? _____

What were the circumstances that caused the client to make changes with his/her use during these times?

2. What has been the longest period of non-using? What did the client find helpful during those periods?

3. What do you identify as the reasons for returning to drinking/drug using/gambling?

4. What is the client's current substance use or gambling goal?

☐ quit all substance use/gambling
☐ maintain abstinence
☐ other_____
☐ cut down on _____
☐ make no changes

5. Previous addiction treatment- No previous treatment attempts- ☐
Yes, **FILL IN TABLE BELOW**

NAME OF FACILITY	DATE	TYPE OF TREATMENT	COMPLETED?

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING TREATMENT HISTORY:

EMOTIONAL HEALTH

PLEASE ANSWER YES OR NO AND PROVIDE INFORMATION ON HOW THE CLIENT HAS COPED AND WHAT SUPPORTS HAVE BEEN UTILIZED

CONCERN	EXPERIENCED IN LAST 90 DAYS	EXPERIENCED IN LIFETIME	SUPPORTS/COPING SKILLS USED
Anxiety- tension, nervousness fears / phobias			
Depression- grief, losses, isolation			
Eating disorders- starving on purpose, binging/purging			
Sexual abuse / sexual assault			
Physical, emotional, mental abuse			
Suicide- suicidal thinking, attempts, self-harm behaviour			
Cognitive- difficulty tracking , concentrating, focusing			
Anger- assaults, aggressive behaviour			
Other trauma (deaths, accidents, other traumatic events)			

OTHER POTENTIALLY EXCESSIVE BEHAVIOURS:
PLEASE CHECK THE BOXES BELOW IF THEY ARE RELEVANT. PROVIDE DETAILS IN THE SPACE PROVIDED. *Ie. Amount of time spent doing this activity, negative life impact, causes financial strain, topic of arguments with loved ones).*

☐ **NONE**

	☑	**DETAILS**
Shopping (excessive money spending)	☐	
Internet overuse (surfing, chatting, blogging, social networking)	☐	
Video Gaming (computer or home systems, online)	☐	
Eating Disorder (starving on purpose, binging purging)	☐	
Sex (pornography, excessive masturbating, visiting sex trade workers, preoccupation with sexual thoughts)	☐	
Other	☐	

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING EMOTIONAL HEALTH (INCLUDE ALL MENTAL HEALTH DIAGNOSIS DETAILS):

FAMILY/SUPPORTS

1. What community is the client originally from? _____

2. Childhood Experiences:

- ☐ Substance abuse
- ☐ Witness to domestic violence
- ☐ Emotional, physical or sexual abuse
- ☐ Foster Care
- ☐ Neglect
- ☐ Divorce/separation of parents
- ☐ Death of a parent
- ☐ Happy home life

3. How does the client describe the current relationship with his/her family of origin?

4. Relationship Experiences:

- ☐ Never been in a relationship
- ☐ Affairs
- ☐ Mental health issues of partner
- ☐ Difficulties talking about feelings
- ☐ Violence/abuse
- ☐ Solid/supportive relationship

5. If the client is currently in a relationship, does the partner struggle with any addiction issues? Please describe.

6. Does the client have any children? ☐ Yes ☐ No
If yes, who has custody of the children? What is the nature of the relationship with the children?

USE THIS SPACE TO PROVIDE MORE DETAIL REGARDING FAMILY, CHILDREN, AND SUPPORTS:

EMPLOYMENT / EDUCATION / LEGAL

1. Current or last occupation? _____

2. Does the client have EAP in the workplace? _____

3. Does the client have a history of learning disabilities or problems? YES ☐ NO ☐
   If yes, what type: _____

4. Are there any literacy issues? YES ☐ NO ☐

USE THIS SPACE TO PROVIDE MORE DETAIL ON EDUCATION & EMPLOYMENT:

LEGAL

1. Any current charges? YES ☐ NO ☐ When is the next court date?
2. If yes, are you on bail? YES ☐ NO What are the charges?
3. Are you on the Sex Offender Registry? YES ☐ NO ☐
4. Do you have any no contact orders? YES ☐ NO ☐
5. Have you, or are you currently banned from an emergency shelter? YES ☐ NO ☐
6. If on probation or parole:
   What charges is the client on probation for?

   Probation or parole officer's name & contact info:

7. Past Offenses (check all that apply):

- ☐ Theft / possession of stolen property
- ☐ Drug charges
- ☐ Weapons offenses
- ☐ Robbery
- ☐ Arson
- ☐ Impaired driving
- ☐ Murder / manslaughter, criminal negligence causing death
- ☐ Other – (specify):
- ☐ Parole / probation violations
- ☐ Forgery
- ☐ Burglary, break & enter
- ☐ Assault
- ☐ Sexual assault / incest
- ☐ Willful damage / mischief

USE THIS SPACE TO PROVIDE MORE INFORMATION ON LEGAL:

_____ _____
Signature of Client Date

_____ _____
Signature of Counsellor Date

St. Joseph's Care Group

GAMBLING SCREENING

If gambling was identified as a problem on page (6) six, please complete Part One and Part Two.

Part One

1) Thinking about the last 12 months, have you bet more than you could really afford to lose?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

2) Thinking about the last 12 months, have you needed to gamble with larger amounts of money to get the same feeling of excitement?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

3) Thinking about the last 12 months, when you gambled, did you go back another day to try to win back the money you lost?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

4) Thinking about the last 12 months, have you borrowed money or sold anything to get money to gamble?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

5) Thinking about the last 12 months, have you felt that you might have a problem with gambling?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

6) Thinking about the last 12 months, has gambling caused you any health problems, including stress or anxiety?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

7) Thinking about the last 12 months, have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

8) Thinking about the last 12 months, has gambling caused any financial problems for you or your household?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

ST. JOSEPH'S CARE GROUP

9) Thinking about the last 12 months, have you felt guilty about the way you gamble or what happens when you gamble?

○ Never ○ Sometimes ○ Most of the time ○ Almost Always

10) In the past 12 months, what was the largest amount of money you have gambled with (to the nearest dollar)?

$

11) Check which of the following people in your life has (or had) a gambling problem:

☐ Father ☐ Brother/Sister ☐ Spouse/Partner ☐ Friend, or someone important in my life
☐ Mother ☐ Grandparent ☐ Child(ren)

12) In the past 12 months, have you ever claimed to be winning money gambling but, weren't really? In fact, you lost. ○ Yes ○ No

13) In the past 12 months, have you ever felt like you would like to stop gambling, but, didn't think you could? ○ Yes ○ No

14) In the past 12 months, have you neglected household or other responsibilities in order to gamble, or to get money to gamble? ○ Yes ○ No

15) In the past 12 months, have you ever hidden betting slips, lottery tickets, gambling money or other signs of betting or gambling from others? ○ Yes ○ No

16) In the past 12 months, have you ever argued with people you live with about how you handle money? ○ Yes ○ No

17) (If you answered "yes" to question #16) Have money arguments ever centred on your gambling? ○ Yes ○ No

18) (If you answered "yes to question #17) Have you had a secret life, regarding your money, because of your gambling? ○ Yes ○ No

19) In the past 12 months, have you ever borrowed from someone and not paid them back as a result of your gambling? ○ Yes ○ No

20) In the past 12 months have you ever lost time from work (or school) due to gambling? ○ Yes ○ No

21) Have you ever used gambling to:

Avoid conflict?	○ Yes	○ No
Change your mood?	○ Yes	○ No
Escape from "life"?	○ Yes	○ No

22) If you borrowed money to gamble or pay debts in the past 12 months, who or where did you borrow from?

Household money	○ Yes	○ No
Spouse/Partner	○ Yes	○ No
Other relatives or in-laws	○ Yes	○ No
Banks, loan companies, or credit unions	○ Yes	○ No
Credit cards	○ Yes	○ No
Loan sharks	○ Yes	○ No
Cashed-in stocks, bonds, or other securities	○ Yes	○ No
Sold personal of family property	○ Yes	○ No
Borrowed on chequing account (passed bad cheques)	○ Yes	○ No
Have (had) a line of credit with a bookie	○ Yes	○ No
Have (had) a credit line with a casino	○ Yes	○ No

23) On a scale of 1-10 (1= no problem with gambling, 10 being a serious gambling problem), how do you rate the level of problems surrounding your gambling? I rate my gambling problem:

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

No problem ← → Serious Problem

24) How many years ago would you have rated yourself a 5 (5 being "moderate degree of problems" on the scale?)

ST. JOSEPH'S CARE GROUP

Part Two

1) Are you seeking help for:

- ☐ Your own difficulties related to a family/significant others 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.

4) Please indicate whether:

- ○ You came to this agency specifically for gambling treatment
- ○ Your gambling problem surfaced in the course of other treatment

5a) Please indicate how often you engaged in each of the following gambling activities in the past 12 months. Please check the most appropriate box.

Gambling Activities	Did not gamble	Less than once a month	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily	Unknown
Played cards for money	○	○	○	○	○	○	○
Played Mahjong for money	○	○	○	○	○	○	○
Played "live" KENO for money	○	○	○	○	○	○	○
Played roulette for money	○	○	○	○	○	○	○
Bets on horses, dogs or other animals	○	○	○	○	○	○	○
Bets on sports	○	○	○	○	○	○	○
Bets on dice games	○	○	○	○	○	○	○
Bought lottery tickets	○	○	○	○	○	○	○
Bought scratch tickets	○	○	○	○	○	○	○
Bought tear open tickets	○	○	○	○	○	○	○

Played bingo for money	○	○	○	○	○	○	○
Played the stock options and/or commodities market	○	○	○	○	○	○	○
Played VLTs	○	○	○	○	○	○	○
Played slots or other non-VLT machines	○	○	○	○	○	○	○
Internet gambling	○	○	○	○	○	○	○
Played pool, golf or some other game of skill for money	○	○	○	○	○	○	○
Participated in sports pools	○	○	○	○	○	○	○
Betting spontaneously on random events/informal bets	○	○	○	○	○	○	○
Some other type of gambling	○	○	○	○	○	○	○

5b) Please indicate the top three types of gambling problems, using the activity numbers in question 5a).

Major 1st other 2nd other

6a) Please indicate how often you gambled in each of the following locations in the last 12 months. Check the most appropriate box.

Locations	Did not gamble	Less than once a month	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily	Unknown
In a commercial casino	○	○	○	○	○	○	○
In a charity gaming club	○	○	○	○	○	○	○
In a bingo hall	○	○	○	○	○	○	○
At the race track	○	○	○	○	○	○	○
At an off-track betting location	○	○	○	○	○	○	○
On the internet	○	○	○	○	○	○	○
On the television	○	○	○	○	○	○	○

On the telephone	○	○	○	○	○	○	○
Lottery kiosk/outlet	○	○	○	○	○	○	○
In family/friends setting	○	○	○	○	○	○	○
In a social club	○	○	○	○	○	○	○
In a restaurant/bar	○	○	○	○	○	○	○
In a school setting	○	○	○	○	○	○	○
In a work setting	○	○	○	○	○	○	○
In a seniors centre/home	○	○	○	○	○	○	○
In a custody/correctional facility	○	○	○	○	○	○	○
Somewhere else in the community	○	○	○	○	○	○	○

6b) 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:

In Ontario % In another province % Outside Canada %