MISSION STATEMENT

Desert Visions and Nevada Skies Youth Wellness Centers provide Native American people culturally relevant behavioral health treatment to intervene in addictive lifestyles, to assist in the development of dignity and self-respect while instilling hope and promoting wellness in adolescents, families and communities.

VISION STATEMENT

Desert Visions and Nevada Skies Youth Wellness Centers are the path to wellness for Native American youth who are in need of substance abuse treatment and other behavioral health care.
IMPORTANT INFORMATION FOR PARENTS/GUARDIANS AND BEHAVIORAL HEALTH PROVIDERS

Please read the following information:

- We recommend that this Application for admission packet be completed by a health professional. If not completed by a health professional, please include a mental health or substance abuse evaluation.

- We encourage you to fax the completed Application for Admissions and to call and leave a message stating that a fax was sent.

- **FAX Number**: 520-562-3415
- **Admission/Intake Telephone number**: 480-338-4867

- A phone screen with the Patient will be performed by a medical provider as part of the admission process.

- A Patient will not be admitted to Desert Visions or Nevada Skies without a legal guardian present at the time of admission unless agreed upon by the guardian, referral source, and treatment team and all required consents and releases have been received.

- Community service may be performed while the patient is enrolled in the Desert Visions or Nevada Skies programs.

- A patient will only be discharged to a legal guardian.

TREATMENT MODEL AND PHILOSOPHY OF CARE

The purposes of the Desert Visions & Nevada Skies Youth Wellness Centers are to support as many Patients as possible in their quest for a substance-free lifestyle. We hope to educate our Patients about the negative impact of substance use on mind, body and spirit so that they in turn may educate others.

The clinical staff at Desert Visions & Nevada Skies use the medical model in viewing alcohol dependence as a disease. Desert Visions & Nevada Skies staff is aware that social and environmental factors may contribute to stressors, which may result in substance use/abuse.

In using the biopsychosocial model, Desert Visions & Nevada Skies accepts the idea that a social problem in the life of an individual may result in psychological problems if not addressed in a timely manner. Desert Visions & Nevada Skies believes that in order to achieve the highest success a therapeutic alliance with Patients and their family is of utmost importance.

Services are individual and culturally relevant to accommodate Patients with dual diagnosis. Patients are introduced to a behavioral approach, utilizing positive reinforcement for appropriate behaviors. Staff will also redirect and provide consequences for inappropriate behaviors. Patients are taught about choices and natural consequences as a result of those choices. The goal of treatment is to better the Patient’s social, emotional and behavioral realm.

The 12-step program and SMART Recovery are used as an adjunct to treatment. In addition, our Patients are taught about Relapse Prevention so as to prepare themselves for re-entry with their family or other providers.
Desert Visions & Nevada Skies Youth Wellness Centers

Admission Criteria

Criteria for Admission/Re-Admission to Desert Visions & Nevada Skies Youth Wellness Centers shall include:

1. Age range between 12 and 18.

2. Must be eligible for direct care from the Indian Health Service.

3. The Patient meets DSM-5 or ICD-10 criteria for substance abuse disorder in accordance with standardized and widely accepted criteria as diagnosed by a credentialed or licensed provider.

   There must be a primary diagnosis meeting DSM-5 or ICD-10 criteria for substance abuse or dependence.

4. Completion of a health and physical examination, done within 30 days prior to admission.

5. Desert Visions/Nevada Skies staff will complete telephone screen with applicant prior to application approval.

6. Legal guardian must accompany patient to Desert Visions/Nevada Skies on admission date to check minor into facility.

The following conditions may preclude admission to Desert Visions or Nevada Skies:

1. Medical instability - any person who is experiencing an acute medical problem that would interfere from benefiting from the treatment program.

2. Actively suicidal, homicidal and/or a history of violent behaviors sufficient to be a threat to staff or patients.

3. Actively psychotic or impairment in reality testing.

4. Refusal to participate in the treatment program.

5. Significant runaway risk – Desert Visions and Nevada Skies are not lock-down facilities.

6. Behavioral problems that would interfere with other residents’ treatment.

7. Intellectually challenged (any person having an I.Q. of 70 or less) or having other equivalent cognitive deficiencies which would interfere with treatment benefits.

8. Concurrent admission of a sibling or close relative.
Desert Visions/Nevada Skies Youth Wellness Center
REQUIRED DOCUMENTS

☐ Copy of Private Insurance and/or Medicaid Card
☐ Recent Health History and Physical Exam within last 30 days
☐ Copy of Immunization Report
☐ TB or PPD placed and read within the last 12 months
☐ Copy of Social Security Card
☐ Copy of Birth Certificate (Bring original on admission)
☐ Copy of Tribal Enrollment
☐ Copy of Individual Education Plan (IEP), if applicable.

Please fax the following documents to **520-562-3415**
**Attention: Intake Department**

Intake Department Phone Number: 480-338-4867

Location Preference: _____ Desert Visions
_________________________ Nevada Skies
_________________________ No Preference
Desert Visions & Nevada Skies Youth Wellness Centers

Patient Identifying Information

Patient’s Name: ___________________________ Date of Birth: __________ M [ F ] Age: ________
S.S.#: ___________________________ Place of Birth: ___________________________
Tribal Affiliation: ___________________________ Degree of Indian Blood: __________ Religion: __________
Address: __________________________________ Home Phone: ___________________________
City: ___________________________ State: __________ Zip: ___________________________

PARENTS:
Mother’s Name: ___________________________ Deceased? ________
Tribal Affiliation: ___________________________ Email: __________
Address: (if different than above) ___________________________ Phone: ___________________________
City: ___________________________ State: __________ Zip: ___________________________

Father’s Name: ___________________________ Deceased? ________
Tribal Affiliation: ___________________________ Email: __________
Address: (if different than above) ___________________________ Phone: ___________________________
City: ___________________________ State: __________ Zip: ___________________________

EMERGENCY CONTACT Name: ___________________________ Relationship to Patient: __________
Home/ Cell Phone: ___________________________ Work Phone: ___________________________ Email: __________

Legal Guardian Name: ___________________________ Relationship to Patient: __________
Tribal Affiliation: ___________________________ Email: __________
Address: ___________________________
City: ___________________________ State: __________ Zip: ___________________________ Phone: ___________________________

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PATIENT IDENTIFICATION NAME (First, M.I. Last) RECORD NUMBER

ADDRESS

CITY/STATE DATE OF BIRTH

Updated 08/15/19
AFTERCARE COUNSELOR:
Name and Title:
Name of Program:
Address:
City: __________________ State: __________________ Zip: __________________
Phone#: __________________ Cell #: __________________ Email: __________________

PROBATION OFFICER:
Name and Title:
Name of Program:
Address:
City: __________________ State: __________________ Zip: __________________
Phone#: __________________ Cell #: __________________ Email: __________________

A. EDUCATIONAL HISTORY:
1. Name of last school attended? __________________________ City __________________ State __________

2. Is Patient still in school? Yes [ ] No [ ] Current grade __________ If No, date last attended __________

3. Has Patient been in special education classes? Yes [ ] No [ ] Does the Patient have an IEP? Yes [ ] No [ ]

4. Has Patient been sent home from school because of drinking or drug use? Yes [ ] No [ ]

5. Has Patient ever been suspended or expelled from school? Yes [ ] No [ ]
Why was Patient suspended or expelled? __________________________

6. Is Patient having any other school problems? Yes [ ] No [ ]
   A. Speech disorder (e.g., lisp, stutter) YES [ ] NO [ ]
   B. Learning problems in school YES [ ] NO [ ]
   C. Grades YES [ ] NO [ ]
   D. Truancy YES [ ] NO [ ]
Comments: __________________________

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Updated 08/15/19
B. FAMILY/RELATIONSHIP HISTORY:
1. Are Patient's biological parents still living together? Yes [ ] No [ ]
2. If parents are separated or divorced, with whom does Patient live? Mother [ ] Father [ ] other [ ]
   If you checked "other", please list. Name(s): _______________________________________
   Relationship: ____________________________________________
3. Is Patient adopted? Yes [ ] No [ ]
4. Does Patient have children? Yes [ ] No [ ]
   If so, how many? ______  Ages _______________________________________

C. LEGAL HISTORY:
1. Does Patient have any charges pending? Yes [ ] No [ ]
   If so, what are they? _______________________________________________________
2. Does Patient have a pending court hearing? Yes [ ] No [ ]
   If yes, when is your court date? _____________________________________________
3. Is Patient court ordered to treatment? Yes [ ] No [ ]
4. Has Patient had previous arrests? Yes [ ] No [ ]
   If so what were the charges? _________________________________________________
5. Has Patient been in treatment before for alcohol or drugs? Yes [ ] No [ ]
   If yes, where? _____________________________________________________________
6. Is the Patient under Child Protective Agency care? Yes [ ] No [ ]
   If yes, what is the Child Protective Service plan? ________________________________

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Updated 08/15/19
D. MEDICAL PROBLEMS AND PHYSICAL CHALLENGES:

1. Is the Patient allergic to medications, foods, insect stings, plants?  YES [ ] NO [ ]
   If YES, what is Patient allergic to? 

2. Asthma?  YES [ ] NO [ ]
3. Diabetes?  YES [ ] NO [ ]
4. Seizure Disorder?  YES [ ] NO [ ]
5. Tuberculosis?  YES [ ] NO [ ]
6. Heart Problems?  YES [ ] NO [ ]
7. Hepatitis?  YES [ ] NO [ ]
8. Other medical problems

9. What medications have been prescribed for the Patient? 

10. Is the Patient pregnant?  YES [ ] NO [ ] If Yes, how many weeks pregnant? 
   Who is providing prenatal care for the Patient?

11. Is the Patient physically challenged? (example: does Patient use a wheelchair, crutches, etc. or have vision or hearing difficulties?) 

E. EMOTIONAL/BEHAVIORAL:

1. Does the Patient have a history of an eating disorder? (Obesity or restrict food intake to keep weight dangerously low, or binge eat and then vomit or exercise to maintain weight?)  YES [ ] NO [ ]
   If YES, describe:

2. Does the Patient have a history of fire setting?  YES [ ] NO [ ]
   If yes, describe:

3. Does the Patient have a history of cruelty to animals?  YES [ ] NO [ ] Describe:

4. History of bedwetting?  YES [ ] NO [ ]

5. Has the Patient been hospitalized for emotional or mental problems?  YES [ ] NO [ ]
   Hospital Location Dates of treatment Reason for Admission

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PATIENT IDENTIFICATION

NAME (First, M.I. Last) RECORD NUMBER

ADDRESS

CITY/STATE DATE OF BIRTH

Updated 08/15/19
6. Has the Patient seen a psychiatrist, psychologist, counselor or traditional healer for emotional/mental problems? YES [ ] NO [ ]

7. Does the Patient have a history of self-injury or suicide attempts? YES [ ] NO [ ]
   Date: ____________________  Method: ____________________  Name of Hospital: ____________________  # Days in Hospital: ____________________  Substance Abuse Involved: ____________________

8. Is the Patient currently self-harmful or suicidal? YES [ ] NO [ ]
   If YES, describe: ____________________

9. Does the Patient have a history of violence toward others? YES [ ] NO [ ]
   If yes, describe:
   a. History of violence to self? (e.g. self-choking, cutting, etc.) YES [ ] NO [ ]
      Describe: ____________________
   b. Has Patient been a victim of violence from others? YES [ ] NO [ ]
      Describe: ____________________

10. Has the Patient ever had psychological testing completed? YES [ ] NO [ ]
    If YES, when? ____________________

11. Has the Patient been involved in a gang? YES [ ] NO [ ]
    If YES, which gang? ____________________
    a. Gang Colors & Attire: ____________________
    b. Describe the Patient's involvement with the gang: ____________________

Has Patient used any of the following? (Please check)

- Alcohol  How much and how often: ____________________

- Sedative Hypnotics/ tranquilizers (Valium, Librium, Phenobarbital, etc.)
  How much and how often: ____________________

- Psychotropic (Stelazine, Cogentin, Thorazine etc.) How much and how often:

- Barbiturates (Quaaludes, Phenobarbital, Nembutal, Tuinal, Seconal)
  How much and how often: ____________________

- Stimulants-amphetamines (Dexedrine, Crystal, Benzedrine, Methedrine, etc.)
  How much and how often: ____________________

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Sleeping pills  If yes, what kind and how much/how often: __________________________________________ 

Opiates (heroin, morphine, opium, etc.) Specify and how much/how often: ____________________________ 

Pain killers (Darvon, Darvocet, codeine, etc.) Specify and how much/how often: ______________________ 

Hallucinogens (LSD, STP, MDA, PCP, mescaline, etc.) Specify and how much/how often: ____________________________ 

Cocaine  If yes, how much/how often: ____________________________________________________________ 

Cannabis (Marijuana)  If yes, how much/how often: _________________________________________________ 

Steroids  Specify and how much/how often: _________________________________________________________ 

Tobacco: Smoking [ ]  How much/How often: ________________________________________________________ 

Chewing [ ]  How much/How often: __________________________________________________________________ 

Caffeine: (Coffee, Soda) How much per day? ____________________________________________________________________ 

Inhalants (sniffing) If yes, how much/how often: ____________________________________________________ 

Other Type:___________________________________ How much and How often: ____________________________ 

Has the Patient had withdrawal or severe hangovers in the past?  YES [ ]  NO [ ]

If YES, which substances caused withdrawal or severe hangovers ____________________________________________ 

______ Has the Patient had Blackouts?  YES [ ]  NO [ ]  If yes please explain ________________________________ 

______ Has the Patient had residential treatment for Substance Abuse?  YES [ ]  NO [ ]

Residential Facility  Dates of treatment  If not successfully completed, WHY? _______________________________ 

______ Has the Patient had outpatient treatment for Substance Abuse?  YES [ ]  NO [ ]

Outpatient Program  Counselor  Dates of treatment  If not successfully completed, WHY? _______________________________ 

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__________

PATIENT IDENTIFICATION  NAME (First, M.I. Last)  RECORD NUMBER

ADDRESS

CITY/STATE  DATE OF BIRTH

Updated 08/15/19
F. Other issues the Patient may need help with:
1. Delinquent (arrested or referred to juvenile court) YES [ ] NO [ ]
2. Run away YES [ ] NO [ ]
3. Juvenile Detention YES [ ] NO [ ]
4. Depression YES [ ] NO [ ]
5. Stealing YES [ ] NO [ ]
6. Possession of weapons YES [ ] NO [ ]

G. TREATMENT ACCEPTANCE/RESISTANCE
Is the Patient willing to come to treatment voluntarily? YES [ ] NO [ ]

H. RECOVERY ENVIRONMENT
1. Who currently lives in the home with the Patient? (list names, ages and relationship to Patient)

2. Is there anyone currently living in the Patient's home who is in poor health? YES [ ] NO [ ]
   If YES, describe condition:

3. Is there anyone currently living in the Patient's home who is an active substance abuser? YES [ ] NO [ ]
   If YES, relationship and substance abused:

4. Is there anyone currently living in the Patient's home who is active in a program of recovery? YES [ ] NO [ ]
   If YES, relationship and circumstances:

5. Does the Patient have access to an Aftercare Program? YES [ ] NO [ ]
   If yes, what organization and contact person:

6. What are the current plans for the Patient after treatment?
   Living Situation:
   School Work:
   Aftercare Program:

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Updated 08/15/19
7. What is the family expectation of the Patient?

8. Family Strengths:

9. Family Liabilities:

10. Additional Information:

11. Explain why Outpatient Treatment is not sufficient at this time:

12. Patient is being referred to DESERT VISIONS or NEVADA SKIES by:

   [ ] Aftercare Counselor  [ ] Probation Officer  [ ] Tribal Court  [ ] Behavioral Health
   [ ] County Court  [ ] School  [ ] Family Doctor  [ ] Attorney  [ ] Parent

Print Name

Signature

Relationship to Patient

Date

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PATIENT IDENTIFICATION

NAME (First, M.I. Last)

RECORD NUMBER

ADDRESS

CITY/STATE

DATE OF BIRTH

Updated 08/15/19
Desert Visions & Nevada Skies Youth Wellness Centers
Inventory Check List (Females at Desert Visions)

Clothing: Absolutely NO gang colors or lettering: NO RED or BLUE. No alcohol/drug/gambling-related logos or skulls on any clothing.

  ____ 1  Jacket or Sweater for hiking and outdoor activities
  ____ 7  Shirts or T-shirts, plain White. No tank tops or tube tops allowed except under t-shirt. No lettering or pictures and no RED or BLUE colors.
  ____ 7  Pairs jeans or slacks that fit – Not oversized or too tight.
  ____ 7  Pair Shorts when weather is warm. No "short shorts" or Cut-offs. Shorts must be no shorter than 4 inches above the knee
  ____ 2  Pairs Sweat pants
  ____ 2  Pairs of Athletic shoes: NO Red or Blue markings. No clogs or sandals
  ____ 1  Shower shoes: (flip-flops or slides)
  ____ 7  Pairs of socks
  ____ Swimming suit (1 piece) (No low or high cuts and no red or blue)
  ____ 7  Briefs or panties (no thongs)
  ____ 5  Bras (No underwire. Sport bras recommended)
  ____  ____ Pejamas or sleeping attire
  ____  ____ Knee length dresses/skirts/dress shoes (optional)

Personal Hygiene: MUST BE NEW and UNOPENED.

  ____ 1  Toothbrush/toothpaste/floss: (No mouthwash containing alcohol)
  ____ 1  Shampoo and conditioner
  ____ 1  Deodorant (non-aerosol)
  ____ 1  Body wash or 4 Bars Soap: (Ivory or non-perfumed hypoallergenic soap)
  ____ 1  Hand/body lotion
  ____ 1  Tampons/maxi-pads/pantry liners

Additional hygiene products will be provided if needed.

DO NOT bring aerosols, cologne, aftershave, body spray or hair spray or gel containing alcohol.

Personal Care:

  ____ 1  Medications (Prescribed only and in original bottles labeled by the pharmacist)
  ____ 1  Over the Counter Acne Medications (i.e. Proactive Solution)

Money, Valuables & Other:

  ____ 1  No more than $20.00 for personal items for your child. You may add to it during your child's treatment.
  ____ 1  Desert Visions & Nevada Skies provides for expenses for special events and activities.
  ____ 1  Stationery-stamps
  ____ 1  Small portable am/fm radio, must have earphones (bring own batteries).

"NO NO's": NO RED or BLUE. DO NOT bring belts, cameras, cell phones, iPods/Mp3 players, portable CD/DVD players, hand-held game systems, jewelry or piercings, pillows, blankets, towels, stuffed animal, food, gum, candy, weapons of any kind, or anything of value. Money and other valuable items will be kept in a locked safe. Alcohol, other drugs, and tobacco products are NOT allowed.

This Sheet may be torn from packet and given to Patient's family

Updated 08/15/19
Desert Visions & Nevada Skies Youth Wellness Centers
Inventory Check List (Males)

Clothing: Absolutely NO gang colors or lettering: NO RED or BLUE. No alcohol/drug/gambling-related logos or skulls on any clothing.

___ 1 Jacket or Sweatshirt for hiking and outdoor activities
___ 7 Shirts or T-shirts, plain White. No tank top t-shirts allowed except under t-shirt. No lettering or pictures and no RED or BLUE colors.
___ 7 Pair jeans or slacks that fit – Not oversized or too tight.
___ 7 Pair shorts when the weather is warm. No “short shorts” or Cut-offs. Shorts must be no shorter than 4 inches above the knee
___ 2 Pairs Sweat pants
___ 2 Pairs of Athletic shoes: NO Red or Blue markings.
___ Shower shoes: (flip-flops or slides)
___ 7 Pairs of socks
___ 2 Swimming trunks (No Red or Blue)
___ 7 briefs or boxers
___ Pajamas or sleeping attire

Personal Hygiene: MUST BE NEW and UNOPENED.

___ Toothbrush/toothpaste/floss: (No mouthwash containing alcohol)
___ Shampoo and conditioner
___ Deodorant: (non-aerosol)
___ Body wash or 4 Bars Soap: (Ivory or non-perfumed hypoallergenic soap)
___ Hand/body lotion

Additional hygiene products will be provided if needed

DO NOT bring aerosols, cologne, aftershave, body spray or hair spray or gel containing alcohol.

Personal Care:

___ Medications (Prescribed only and in original bottles labeled by the pharmacist)
___ Over the Counter Acne Medications (i.e., Proactive Solution)

Money, Valuables & Other:

___ No more than $20.00 for personal items for your child. You may add to it during your child’s treatment.

Desert Visions & Nevada Skies provides for expenses for special events and activities.
___ Stationery-stamps
___ Small portable am/fm radio, must have earphones (bring own batteries).

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