Firebird Earth Medicine Retreat
Program Application

The application process has three sections: When these are filled out, please either fax or email completed forms to transform@firebirdearthmedicine.com

1) The Application
2) The Psychological Referral Form
3) The participant History and Medical Information

Contact Information

Mailing Address:
Firebird Earth Medicine
4979 4200 Rd.
Crawford, CO 81415
Ph: 303-859-7385
Fax 970-921-5420
transform@firebirdearthmedicine.com

Our work with these retreat programs is about safety and a good experience with psychedelic-enhanced healing and growth events. Participants will bring their own prescription for events and administer it themselves on campus with integration staff attending participants as they move through their process and then engaging participants in appropriate retreat event program during the two-week stay. Participants can stay less time if they choose and can ask for extended stay as well if they feel like they need more time to do their process work.

All programs would include Gwen Diaz AyD working with accepted participants before they arrive, to make sure they are healthy and able to do the retreat program events safely during the time they are on our campus retreat center.

There are ruleouts for these retreat programs including:
Any extreme medical or mental health issues. If you have something going on that we need to know about, please add it into the application so we can review it and decide if the retreat program you have chosen is something that we feel is safe for you to do.

Firebird Earth Medicine Application

Date: _____

Name of client referral: _____ Length of treatment:_____

D.O.B.:_____ SSN:_____

Referring entity and title _____

Please fax this completed form to 970-921-5420 or email transform@firebirdearthmedicine.com (Attention: Admissions)

Please choose

1) Program One - Coming Back to Life Trauma Psychedelic Enhanced Retreat Program
2) Program Two – Becoming Extraordinary Psychedelic Enhanced Growth Program
3) Program 3Three - End of Life Psychedelic Enhanced Retreat Program for participants with a terminal diagnosis

Please list which retreat program you are interested in _____

At this time, we can schedule on an individual or group basis: Are you coming in as an individual or group _____ If group: How many _____

Date you would like to schedule your retreat center event. _____

Alternate date if that date is not available _____

Demographic Information:

Today's Date _____

Person Filling out Application _____

Applicant's Legal Name
_____

Preferred Name (if different)_____

Date of Birth __ /__ /____ SSN Gender _____

Address _____ City _____

State/Zip _____

Phone _____

Email_____

Marital Status: □ Married □ Divorced □ Widowed □ Single

Race/Ethnicity:
□ American Indian or Alaskan Native □ Hispanic or Latino or Spanish Origin of any race
□ Asian □ Native Hawaiian or other Pacific Islander
□ Black or African American □ White □ Other/Prefer not to say

Emergency Contact:

Name
_____

Address _____ City_____

State/Zip _____

Phone _____ Email _____

Occupation _____ Marital Status: □ Married □ Divorced □ Widowed □ Single

(1) Is there a court appointed legal Guardian, Health Care Proxy, or Power of Attorney for Medical or Financial
purposes? □ Yes □ No
If yes, please fill in information below, and submit a copy of documentation for our records:

Name _____ Phone _____

Email _____

Address_____ City_____

State/Zip _____

(2) Referred by:_____

(3) Person financially responsible: _____

(4) What are your hopes for being admitted to the Firebird Earth Medicine psychedelic enhanced retreat programs.

_____
_____
_____
_____
_____

(6) Other information that may be helpful in your care and treatment:

_____
_____
_____

General Medical Information:

Primary Care Provider Name: _____

City/state_____

Phone _____ Fax _____ Year PCP began seeing resident _____

Health Insurance Co. _____

Phone _____

Address _____ City _____

State/Zip _____

Policy # _____ Group #
_____

Policy Holder _____ Policy Holder's Date of Birth ____/_____/_____

Medicare _____ Medicaid _____

Personal Medical History:

Medical Requirement: If the applicant has had a physical examination within the past 90 days, we will require a copy of that record.

Please indicate whether applicant has had any of the following medical problems, and approximate dates:

_____ High cholesterol
_____ High Blood Pressure
_____ Kidney disease
_____ Diabetes
_____ Thyroid problem
_____ Seizure
_____ Asthma/Lung Disease
_____ Head Injury
_____ Lyme's disease
_____ Heart Disease (specify) _____ _____
Cancer (specify) _____
Other(specify) _____
Major Surgeries: _____

Allergies or reactions to medications:
_____
What medical aids or devices such as glasses, CPAP, prosthesis, are you currently using?
_____

_____

Date of your most recent immunizations:
Hep A _____ Hep B _____ Influenza (flu Shot)_____ MMR _____ Pneumovax (pneumonia)_____
Tetanus _____ Meningitis _____ Varicella shot _____ Chicken Pox illness ____
Tdap (tetanus & pertussis) _____ Covid-19
Tobacco Use
Cigarettes: □ Never □ Quit Date_____ □ Current Smoker: Packs/day ___ #of yrs _____

Other Tobacco: □ Pipe □ Cigar □ Chew □ E cigarettes/vaporizer
Are you interested in quitting? □ Yes □ No

Alcohol Use
Do you drink alcohol? □ No □ Yes (Number of drinks per week) _____
When was your last drink? _____
Has your alcohol use ever been a concern for you or others? □ Yes □ No
Substance Use
Do you use any recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No
When did you last use any substances _____
List all current prescribed medications (including psychiatric and medical):
List any non-prescription medicines, vitamins, remedies, birth control pills, or herbs you take:
Medication Dose Times per day Medication Dose Times per day

Medication Dose Times per day Medication Dose Times per day

All incoming participants need to be able to administer their own medications and will be given a lock box to hold their medications.

Firebird Earth Medicine
Psychological or Psychiatric Referral Form

Please have this form completed by client's psychiatrist, licensed therapist, or psychologist. If the individual is on medications the prescribing physicians name and dates of any med changes needs to be added on for continuity of care.

Date: _____

Name of client referral: _____ Length of treatment:_____

D.O.B.:_____ SSN:_____

Referring entity and title _____

Office Address:_____
Street City
_____
State Zip code

PH:_____ FAX:_____

Email: _____

Guardian: Yes No
If yes, list name and attach a copy of guardianship paperwork: _____

_____

Participants Diagnosis:

Please complete the DSM-V or DSM-IV-TR code and current diagnoses for the referred client:
Code Diagnosis
_____/_____

_____/_____

_____/_____

_____/_____

_____/_____

_____/_____

Current Mental Status:

YES NO Suicidal History
Ideation Dates: _____ Method _____
Plan Dates: _____ Method _____
Attempt Dates: _____ Method _____

YES NO Aggression History
_____ Verbal Who with _____ When_____
_____ Physical Who with _____ When_____
_____ Assault History Dates_____ Method _____

YES NO Arrest Record
Dates _____ Reason_____
Current Status _____ Probation/Parole _____
Dates _____ Reason_____
Current Status _____ Probation/Parole _____

YES NO Sexual Abuse Victim / Perpetrator
YES NO Physical Abuse Victim / Perpetrator
YES NO Substance Abuse
Type
____ Cigarettes
____ Caffeine
____ Medication
____ Alcohol
____ Illegal (List) _____
_____
_____
____ Other _____

YES NO Recent Trauma _____
YES NO Homeless _____
YES NO Family Support _____
YES NO Delusions
Type:
____ Grandiose
____ Somatic
____ Religious

____ Other

YES NO Hallucinations
Type:
____ Auditory
____ Visual
____ Other

YES NO Self Abuse Is this under control at this time _____

YES NO Appropriate Affect
Type:
____ Animated
____ Blunted
____ Flat
____ Inappropriate
____ Labile
____ Constricted
____ Other

YES NO Participant has Judgement / Insight relating to safety of self / others: to include children and animals.

YES NO Independent Living Skills
____ Regular staff support for daily prompting.
Please add additional comments: _____
_____

Current Psychiatric Prescribed Medications:

Please write in below or attach a current medication record.

Medication	Dose	Frequency	Rationale

PRN Medications

Medication	Dose	Frequency	Rationale

_____/_____/_____/_____

_____/_____/_____/_____

PSYCHIATRIST, PSYCHIATRIC NURSE, PSYCHOLOGIST, LICENSED THERAPIST SIGNATURE: _____

PSYCHIATRIST, PSYCHIATRIC NURSE, PSYCHOLOGIST, LICENSED THERAPIST NAME AND TITLE PRINTED _____

DATE: _____

Please add any additional comments here: _____

_____

Firebird Earth Medicine
Participant Medical and Mental Health History

Client Name: _____
Date of Birth: _____ Gender M F Other_____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Email Address: _____ Phone: _____

Date of Last Physical Exam: _____
Do you feel able to participate in outdoor activities at this time? _____

Medical History

Family History: Please identify biologically related family medical issues.

Disease Type	Family Members Diagnosed	Deceased Yes or No
Cancer Type		
Bleeding Disorder		
Diabetes		
Genetic Disorder		
Cardiovascular Disease		

Allergies Anyone with extreme animal related allergies should not do this program.

Client Allergies	List Allergies	List reactions	Do you have something to work with this allergy?

Medication Allergies/_____/_____/_____
Food Allergies____/_____/_____/_____
Animal Allergies___/_____/_____/_____
Environmental___/_____/_____/_____

Medications and Supplements:
Please list ALL medications including routine, as needed meds, nutritional supplements, herbs, vitamins and over the counter meds OR check here ____ if medication list is attached.

Medications
Name Dose Time Reason Prescriber
_____/_____/_____/_____/_____

_____/_____/_____/_____/_____

_____/_____/_____/_____/_____

_____/_____/_____/_____/_____

_____/_____/_____/_____/_____

Current Medical Diagnoses / Significant Health Conditions / Significant Surgeries:

Last dental appointment: _____ Is ongoing work needed: _____

Last Vision exam: _____ Doctor? _____

Is participant up to date on age-appropriate vaccines? YES NO

Date of last tetanus: _____ Date of last Covid vaccine: _____

Is participant free of any communicable disease YES NO
If no, please explain _____

_____

Healthcare Provider name and title (PA, MD, DO or NP): _____

Healthcare Provider signature; _____

Firebird Earth Medicine
Family and Personal History

Name of participant:
_____

Age: _____ DOB: ____/____/_____ SS# ____/___/_____ PH: _____

Address:_____ City:_____ State: _____

Person providing information: Name: _____ Relationship: _____

Phone:_____ Cell: _____

Is there a history of mental illness and / or alcohol and drug abuse with the participant?
YES NO If yes list Type :_____ date of last use: _____

Has the participant ever been hospitalized YES NO (if yes please provide name(s) of hospital(s)
Hospital: _____ Aprox Dates: _____

Hospital: _____ Aprox Dates: _____

Hospital: _____ Aprox Dates: _____

Hospital: _____ Aprox Dates: _____

Is the participant currently being provided case management through a mental health agency? YES NO (If yes please provide the following information)

Name of agency: _____ Address:_____

Case Manager: _____ Phone: _____

Please describe any limitations the participant may have with regard to living skills:

Gateways To Transformation LLC & Firebird Earth Medicine
4979 4200 Rd., Crawford, CO 81415
Phone: (303) 859-7385 Fax 970-921-5420

HOLD HARMLESS AGREEMENT

The undersigned states as follows: I acknowledge that any program applied for and accepted into at Gateways to Transformation Retreat Center including any Firebird Earth Medicine psychedelic enhanced retreat programs, indoor or outdoor nature-based wilderness and ecotherapy as well as horse activities contain inherent risks of injury and damage to me personally and to my equipment. Knowing these facts, I nevertheless, in consideration to your acceptance of this form, hereby for myself and my heirs, executors, and administrator, waive, release, discharge and hold harmless Gateways To Transformation's Phoenix Rising Programs, Gateways To Transformation Retreat Center and Firebird Earth Medicine, its owners, directors, officers, employees and all individual members thereof and all other persons and or organizations, in any way connected with these events, property, therapy sessions, learning sessions, lessons or any other activity described herein, their representatives, heirs executors administrators, and assignees from any and all right, claim or liability for damages or for any and all injuries that might be sustained by me, including injuries to animals or from any and all claims of any kind of nature that I might have as a result of, or arising from my participation in

any activity that I have freely chosen to do. Further I do hereby acknowledge that this release will extend to any insect bites, accidents, damages, or claims arising out of my participation, caused by my own act or the acts of anyone or any animal within my control. I further agree that I will defend, indemnify, and hold harmless Gateways To Transformation's Phoenix Rising Programs, Gateways To Transformation Retreat Center and Firebird Earth Medicine, it's owners, directors, officers, members, and agents or any of them against all claims, demands and causes of action including court costs, and attorney fees, directly or indirectly rising from any action or other proceeding brought by, prosecuted for my benefit, contrary to the release extended to all claims of ever kind and nature what-so-ever. I give my permission for emergency medical diagnosis or treatment for myself in the event that I am unconscious or unable to make my own decisions. This will be limited to emergency first aid as needed and either transportation to a medical facility or contacting emergency transport as needed.
Non - counseling session photos may be taken for use in advertising the Gateways to Transformation's Phoenix Rising Programs, Gateways To Transformation Retreat Center and Firebird Earth Medicine. In signing this, I agree to have photographs taken for the purpose of advertising during demonstrations or Gateways events, but not for Therapy clients of Gateways to Transformation.

WARNING

Under Colorado law and equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant of equine activities resulting from the inherent risk of equine activities.

Participants are responsible for their own safety and do hereby acknowledge that this release will extend to any accidents, damages, or claims arising out of their own disregard of instructions not to handle this horse specifically, caused by my own act or the acts of anyone or any animal within my control. I further agree that I will defend, indemnify, and hold harmless Gateways To Transformation's Phoenix Rising Programs, Gateways To Transformation Retreat Center and The Phoenix Rising Wilderness School, it's owners, directors, officers, members, and agents or any of them against all claims, demands and causes of action including court costs, and attorney fees, directly or indirectly rising from any action or other proceeding brought by, prosecuted for my benefit, contrary to the release extended to all claims of ever kind and nature what-so-ever.***

_____ _____
Signature of Participant Date

_____ _____
Signature of Parent or Guardian if Participant is under 18 years Date

_____
Phone where Parent or Guardian can be reached if needed

Address

Email Address