

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

**This application package contains 3 parts**

Part 1 of the application is to be completed by you.

Part 2 is to be completed by your referral worker. The referral worker can be either a NNADAP worker, a CHR, counselor or a mental health worker. Part 3 is to be completed by your family physician or nurse practitioner.

Once these forms are completed, your referral worker can forward them to the Addictions Recovery Program at Carrier Sekani Family Services in Vanderhoof. Forms can be faxed to our confidential fax number found on the back page of the package. Once we receive the completed application package, a counselor will then contact you to discuss how we can best meet your needs at camp. **If you do not have a referral worker, please contact the ARP intake worker at 1-866-567-2333. The Addictions Recovery Program will assist you in obtaining a referral worker.**

Your information will be treated as private. All client files are kept in a locked cabinet to which only counselors have access. To keep people safe, we may have to share information regarding, self-harm, the harm of others or child abuse.

**\*\* The Addictions Recovery Program must receive your application at least 4 weeks before the date of the camp you would like to attend.\*\***

**All guests must be alcohol and/or substance free for 1 week (7 days) prior to attending**

**Part 1- Guest Information**

Please complete part 1 and answer all questions to the best of your ability. If you need assistance please call your referring worker.

**Please print**

Last name: \_\_\_\_\_

Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (dd/mmm/yy) Age: \_\_\_\_\_  M  F

First Nations Identity:

Marital Status:

- |                                     |                                 |                                    |                                  |  |
|-------------------------------------|---------------------------------|------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Status     | <input type="checkbox"/> Single | <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed | <input type="checkbox"/> Non-status                              |
| <input type="checkbox"/> Common-law | <input type="checkbox"/> Inuit  | <input type="checkbox"/> Married   | <input type="checkbox"/> Métis   | <input type="checkbox"/> Divorced <input type="checkbox"/> Other |

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Message: \_\_\_\_\_

Thank you for applying to Ormond Lake Cultural Healing Camp.

**Youth Intake Package**  
**Ormond Lake Cultural Healing Camp (OLCHC)**  
**Guest Intake and Goal Setting**

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 First Nation/Band name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Status Number: \_\_\_\_\_  
 \_\_\_\_\_ Personal Health Number/BC Care Card#

Address of Organization: \_\_\_\_\_ Referral Worker's Name: \_\_\_\_\_  
 \_\_\_\_\_ Referral Worker's Title: \_\_\_\_\_  
 \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Fax: \_\_\_\_\_

**A Physical Needs.**

1. Do you have any medical issues? Please check all that apply.

- Heart condition (circle)      Angina      Hypertension      Surgery
- HIV/AIDS
- Cancer
- Seizures      Epilepsy      (circle) date of last seizure \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- FASD
- Diabetes      Do you manage blood sugar levels by pills \_\_\_\_\_ or injections? \_\_\_\_\_  
 What are your target levels? \_\_\_\_\_
- Arthritis
- Physical Impairment (circle) Vision      Hearing      Mobility
- Hepatitis      A      B      C (circle)
- Tuberculosis-TB       Active       Dormant
- Asthma
- Other: \_\_\_\_\_

2. Are you taking any medications including traditional medicine?       yes       no

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Do you have allergies to any medications?       yes       no

If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Youth Intake Package**  
**Ormond Lake Cultural Healing Camp (OLCHC)**  
**Guest Intake and Goal Setting**

4. Do you have any food allergies?  yes  no  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Have you ever been hospitalized as a result of allergy to food or medication?  yes  no  
 When? Date      /      /     

6. Are you waiting for surgery for any health conditions?  yes  no  
 If yes, what is the surgery for and when is the scheduled date? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Have you recently had surgery?  yes  no  
 If yes, what was the surgery for and when was it? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Are there any other health conditions that you have that we should be aware of? Please describe:  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Do you have any special dietary needs that we should be aware of? Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Are you able to walk independently up and down stairs?  yes  no  
 11. Do you require bathroom or bathing aids?  yes  no  
 12. Are you allergic to bees?  yes  no  
 13. Do you have an epi pen?  yes  no  
 14. Are you pregnant? Due Date:      /      /       yes  no

**B. Emotional Needs.**

1. Please indicate any past or present issues you are dealing with:

Issue	Present	Past	Issue	Present	Past
Confusion of sexual identity	<input type="checkbox"/>	<input type="checkbox"/>	Inability to express emotions	<input type="checkbox"/>	<input type="checkbox"/>
Foster/Adoption	<input type="checkbox"/>	<input type="checkbox"/>	Self-harm	<input type="checkbox"/>	<input type="checkbox"/>
Abandonment	<input type="checkbox"/>	<input type="checkbox"/>	Grief & Loss	<input type="checkbox"/>	<input type="checkbox"/>

**Youth Intake Package**  
**Ormond Lake Cultural Healing Camp (OLCHC)**  
**Guest Intake and Goal Setting**

- |                     |                          |                          |                     |                          |                          |
|---------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Anxiety             | <input type="checkbox"/> | <input type="checkbox"/> | Spiritual abuse     | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional abuse     | <input type="checkbox"/> | <input type="checkbox"/> | Depression          | <input type="checkbox"/> | <input type="checkbox"/> |
| Cultural oppression | <input type="checkbox"/> | <input type="checkbox"/> | Victim of Gang Rape | <input type="checkbox"/> | <input type="checkbox"/> |
| Boundaries          | <input type="checkbox"/> | <input type="checkbox"/> | Victim of Rape      | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug abuse          | <input type="checkbox"/> | <input type="checkbox"/> | Self-Hatred         | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol abuse       | <input type="checkbox"/> | <input type="checkbox"/> | Verbal abuse        | <input type="checkbox"/> | <input type="checkbox"/> |
| Prescription drug   | <input type="checkbox"/> | <input type="checkbox"/> | Lack of trust       | <input type="checkbox"/> | <input type="checkbox"/> |
| Domestic abuse      | <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse        | <input type="checkbox"/> | <input type="checkbox"/> |
| Domestic violence   | <input type="checkbox"/> | <input type="checkbox"/> | Low Self Esteem     | <input type="checkbox"/> | <input type="checkbox"/> |
| Neglect             | <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse      | <input type="checkbox"/> | <input type="checkbox"/> |
| Bullying            | <input type="checkbox"/> | <input type="checkbox"/> | Rage                | <input type="checkbox"/> | <input type="checkbox"/> |

2. Have you ever had suicidal thoughts?  yes  no
3. Have you ever participated in groups before?  yes  no
4. Do you feel ready and willing to participate in intensive group work?  yes  no
5. Please describe your experience in groups.

---



---



---

6. Do you have difficulty identifying or expressing emotions?  yes  no
7. Are you on any anti depressant medications?  yes  no
8. Are you on any anti anxiety medications?  yes  no
9. Are you on any mood altering medications?  yes  no

If yes, please list: \_\_\_\_\_

---



---

10. Please describe how you deal with anger. (Example: Angry outbursts, yelling, storming out, throwing Objects, and/or withdrawing.) \_\_\_\_\_

---



---

11. What is your anger threshold?  Low  Medium  High

12. Have you ever been diagnosed by a physician or psychiatrist foe any mental illness?

Bi-polar  Schizophrenia  Depression  Other \_\_\_\_\_

What are you doing to stabilize this condition? \_\_\_\_\_

---



---

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

Do you have feeling of extreme sadness, depression, anxiety or panic attacks? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

13. Are you a youth in care? MCFD?  yes    no  
 If yes, how long have you been in care? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

14. Have you had a stressful life event occur? (For example, money problems, birth, death, divorce, relocation, violence, diagnosis, of a medical condition) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15. What key issues would you like to work on? (Anger, grief & loss, depression, sexual abuse, low self esteem, etc) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

16. Please describe 3 goals you have for your time at Ormond Lake Cultural Healing Camp.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**C. Social Support**

1. Who do you go to in your community for support?	Please indicate below.		
	Weekly	Bi-weekly	Monthly
<input type="checkbox"/> Family	_____	_____	_____
<input type="checkbox"/> Friends	_____	_____	_____
<input type="checkbox"/> Religious Organizations	_____	_____	_____
<input type="checkbox"/> Cultural Organizations	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

2. Is this arrangement working for you? Explain. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Youth Intake Package**  
**Ormond Lake Cultural Healing Camp (OLCHC)**  
**Guest Intake and Goal Setting**

3. Provide 2 adult/mentors supports you have.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

4. Living Arrangements:

Do you live with your parent (s)

yes  no

If no, who do you live with? \_\_\_\_\_

Who is your legal guardian? \_\_\_\_\_

Do you live in a group-home setting?

yes  no

Do you live with your guardian?

yes  no

Living with friends

yes  no

Living with extended family

yes  no

5. Education:

Are you attending school?

yes  no

Name of current or last school attended: \_\_\_\_\_

What grade are you in or last completed: \_\_\_\_\_

**D. Spiritual/Cultural Needs**

1. Please identify any cultural practices that help in your healing. (For example, cultural events, native healers and self-healing practices) \_\_\_\_\_

**E. Probation:**

Are you currently on probation?

yes  no

If yes, what is the name of you probation Officer? Name: \_\_\_\_\_

**F. Mental Health Needs**

1. Have your parents or grandparents attended a residential school?

yes  no

If you answered yes, how has this impacted your life? \_\_\_\_\_

Thank you for applying to Ormond Lake Cultural Healing Camp.

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

2. Can you identify past traumas in your life that effect your well-being? \_\_\_\_\_

---

3. Have you ever attempted suicide?  yes  no  
 If so, when? \_\_\_\_\_  
 Have you had suicidal thoughts recently (i.e. last 6-12 months)?  yes  no

**If you attempted suicide in the last six months, you will need to fill out a suicide risk assessment form.**

4. Do you see/attend:

	Weekly	Bi-weekly	Monthly
<input type="checkbox"/> Therapist or Counselor	_____	_____	_____
<input type="checkbox"/> Alcohol & Drug Worker	_____	_____	_____
<input type="checkbox"/> CHR or Health Professional	_____	_____	_____
<input type="checkbox"/> Peer Support Program	_____	_____	_____
<input type="checkbox"/> Medicine Person	_____	_____	_____
<input type="checkbox"/> AA, NA Meetings	_____	_____	_____
<input type="checkbox"/> Group Therapy Programs	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____

5. Is this support working for you? Explain.  yes  no

---



---

6. Have you ever attended OLCHC in the past?  yes  no

7. Have you engaged in additional healing programs since the last time you attended OLCHC?\* (For example, treatment centre, healing circles, cultural practices, physical activities, sports, journaling, self-help books, volunteer work, other)  yes  no

\_\_\_\_\_

If not, why? \_\_\_\_\_

---



---



**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

**House Rules for Ormond Lake Cultural Healing Camp**

As a participant of Ormond Lake Cultural Healing Camp I agree to the following:

- To remember that I am a representative of my community and nation and will conduct myself by respecting the traditional territory of Nadleh Whut'en, the elders, Addiction Recover Program (ARP) staff, other campers and myself.
- No illegal substances are permitted on OLCHC premises.
- If a counselor or another client suspects use of alcohol or drugs, ARP staff will check my bags and personal belongings and confiscate any items not permitted at OLCHC.
- If I break the house rules by using alcohol and/or drugs, I will be brought to the Healing Circle for a group discussion, if I refuse, I will be asked to leave the camp immediately.
- I will not verbally abuse other campers or staff or use offensive language while at camp.
- I will not physically threaten through the use of violence or intimidation towards clients or ARP staff. If I do I will be asked to leave immediately.
- I will smoke 3 meters away from the main cabin doors or in designated smoking areas only and I will use the receptacles for cigarette butts.
- I will respect everyone's feelings and space.
- I will respect the animals that surround us both tame and wild.
- I will enter other cabins by invitation only.
- I will only go on boat rides with licensed motor boat operators.
- I will wear a life jacket at all times when in a boat or canoe.
- I will wear a seat belt when traveling in CSFS vehicles.
- Children are not to be in the kitchen during times of food preparation.
- I will inform ARP staff and chaperons where I will be going when I go on walks and my whereabouts at all times.
- Any child under 19 years of age must be accompanied by a parent/guardian or chaperone.
- I will turn in all my medication, prescribed and over the counter, to ARP staff to be secured for safe keeping. I am responsible for taking my own medication at the appropriate times. ARP staff are only to witness me taking my medication.
- I will clean up after myself, and if I am attending a family camp, I will ensure that my children clean up after themselves as well.
- I agree to have my name added to the rotating chore list.
- I will not engage in sexual activity with other campers or ARP staff or counselors.

**My signature indicates that I understand and agree to follow the Ormond Lake Cultural Healing Camp House Rules.**

Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

**Consent to Attend and Participate in Treatment**

I, (client's name, PLEASE PRINT) \_\_\_\_\_, consent to attend and participate at OLCHC and I have reviewed the following points with my Referral Worker and initialed as a confirmation of my understanding of the following points:

1. \_\_\_ I understand that if I do not abstain from the use of alcohol and/or drugs at least 1 week (7 full days) prior to intake, I will be immediately discharged from the program.
2. \_\_\_ I understand that an incomplete application and lack of supporting documentation delays the processing of my application and confirmation of an intake date.
3. \_\_\_ I consent to the ARP Intake Worker to contact the referral agencies, such as CHR, NNADAP, CHN, Band social worker, Medical Practitioner's, etc. to obtain clarification on information included in this application for treatment. If on provincial assistance, I agree that the Intake Worker can release confirmation of my intake and discharge dates to my Employment Assistance Worker.
4. \_\_\_ I understand the Intake Worker will notify my referral worker by a Confirmation Letter to confirm my acceptance to treatment.
5. \_\_\_ While in treatment, I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.
6. \_\_\_ I have reviewed and completed this application for treatment with my referral worker, answering all questions and providing all information truthfully and thoroughly to the best of my ability.

Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting

**Consent for the Release of Confidential Information (please print)**

I, \_\_\_\_\_ hereby give permission to OLCHC staff to contact the referral worker(s) listed below for the release of information in regard to pre-treatment conference call, progress during treatment, aftercare planning and Final Discharge Report.

Organization \_\_\_\_\_

Referral Worker's Name \_\_\_\_\_

Title \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Alternate contact person \_\_\_\_\_

(The alternate contact person is for confirmation or admission processing only. The alternate contact person will not be included in the release of confidential information prior to, during, or after treatment). The client may change or revoke this release at anytime by giving notice in writing to Addictions Recovery Program at Carrier Sekani Family Services. It is up to the client to inform their referral worker of the change. THIS FORM WILL EXPIRE ONE YEAR AFTER IT IS SIGNED UNLESS REVOKED.

Client's Signature \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
in the Province of British Columbia.

Referral Worker's Signature \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
in the Province of British Columbia.

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

**Boat and Wildlife Disclaimer**

I \_\_\_\_\_ have read the Boat Safety section and the Wildlife orientation section of this package. By signing I acknowledge that from myself, my heirs, executors, administrators and assigns, waive any claims to which I may become entitled for injury, death, damage to or loss of property and release the Nadleh Whut'en Carrier Nation and Carrier Sekani Family Services and their respective Directors, Council members, employees, agents and servants from any claims, demands, actions or causes of action rising out of or in consequence of any loss, injury, or damage to my person or property incurred while traveling to or from, attending at or participating in the camp.

Participants Signature \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
in the Province of British Columbia.

Witness Signature \_\_\_\_\_

Witness Name and Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

**Waiver and Release**

In consideration of acceptance of my application to attend CSFS Ormond Lake Cultural Healing Camp I, for myself, my heirs, executors, administrators and assigns, waive any claims to which I may become entitled for injury, death, damage to or loss of property and release the Nadleh Whut'en Carrier Nation and Carrier Sekani Family Services and their respective Directors, Council members, employees, agents and servants from any claims, demand, actions or causes or action arising out of or in consequence of any loss, injury, or damage to my person or property incurred while traveling to or from, attending at or participating in the camp.

Participants Signature \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
in the Province of British Columbia.

Witness Signature \_\_\_\_\_

Witness Name and Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

**Part 2—Referral Worker's Assessment**

Part 2 is to be completed by the referring worker only. Please answer all of the questions in this section.

**Please print**

Guest Name: \_\_\_\_\_

Camp Name: \_\_\_\_\_ Camp Dates \_\_\_\_\_

Referral Worker's Name: \_\_\_\_\_

Referral Worker's Phone: \_\_\_\_\_

Referral Worker's Emergency Phone: \_\_\_\_\_

Referral Worker's Fax: \_\_\_\_\_

**A. How do you believe your guest would benefit from this program?**

\_\_\_\_\_  
\_\_\_\_\_

**B. Is the application ordered, if so by whom?**

yes  no

If yes, please explain. \_\_\_\_\_

**C. Has the guest attended previous treatment or healing programs?**

yes  no

If yes, please list which programs and date(s) attended:

Program	Dates
_____	_____
_____	_____
_____	_____

**D. What healing progress has been made by your guest?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Support System   | <input type="checkbox"/> AA                      | <input type="checkbox"/> NA                                |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Therapy/Counseling      | <input type="checkbox"/> Traditional Activities/Ceremonies |
| <input type="checkbox"/> Group Therapy    | <input type="checkbox"/> Community Interventions |  |

**Referral Worker please review checklist with your guest. Please check.**

- Have you seen this guest prior to filling out this form?
- Is your guest a survivor of trauma?
- 19 years of age or older?
- Free of misuse of alcohol and drugs for 3 weeks?
- Able to identify at least 2 peer supports in their community?
- Willing to attend, participate and remain in each day of the program?
- Able to not be disruptive to group process?
- Are childcare arrangements in place for your guest?



**Youth Intake Package**  
**Ormond Lake Cultural Healing Camp (OLCHC)**  
**Guest Intake and Goal Setting**

2. Is your guest on any medications including traditional medicine?  yes  no

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does your guest have any food allergies?  yes  no

Allergen	Moderate	Severe	Mild
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If severe, does your guest have a documented plan for treatment?  yes  no

4. Does your guest have any special dietary needs? Please specify:

---



---

5. Is your guest able to walk up and down stairs?  yes  no

6. Is your guest pregnant?  yes  no

**\*\*OLCHC does not accept pregnant guests during their 1st and 3rd trimesters\*\***

**G. Guest History**

Please indicate any past or present issues your guest is dealing with:

Issue	Present	Past	Issue	Present	Past
Confusion of sexual identity	<input type="checkbox"/>	<input type="checkbox"/>	Inability emotions	<input type="checkbox"/>	<input type="checkbox"/>
Foster/Adoption	<input type="checkbox"/>	<input type="checkbox"/>	Self-harm	<input type="checkbox"/>	<input type="checkbox"/>
Abandonment	<input type="checkbox"/>	<input type="checkbox"/>	Grief & Loss	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual abuse	<input type="checkbox"/>	<input type="checkbox"/>
Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Cultural oppression	<input type="checkbox"/>	<input type="checkbox"/>	Victim of Gang Rape	<input type="checkbox"/>	<input type="checkbox"/>
Boundaries	<input type="checkbox"/>	<input type="checkbox"/>	Victim of Rape	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Self-Hatred	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	Verbal abuse	<input type="checkbox"/>	<input type="checkbox"/>
Prescription drug	<input type="checkbox"/>	<input type="checkbox"/>	Lack of trust	<input type="checkbox"/>	<input type="checkbox"/>
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>
Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	Low Self Esteem	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>
Bullying	<input type="checkbox"/>	<input type="checkbox"/>	Rage	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for applying to Ormond Lake Cultural Healing Camp.

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

2. What do you think the guest's key issues are? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. To your knowledge does the guest have a history of violent behavior?  
What kind of behavior has been exhibited?

- Property Damage       Theft       Assault       Other

4. Does the guest have potential for violent or threatening behavior?       yes     no  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Has the guest ever been charged with a criminal offence?       yes     no  
If yes, indicate charge(s), outcome(s) and date(s). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Are there active:

- Parole orders  
 Probation conditions  
 Copy of Probation or bail orders (**MUST INCLUDE DOCUMENTS**)

7. Was the treatment court ordered?       yes     no  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**H. Preparation & Aftercare**

**Please check**

1. Can the guest share in a group setting?       yes     no

2. Is the guest free of crisis?       yes     no  
If no, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting

3. Is the guest in an ongoing working relationship with the referring person?  yes  no  
If yes, how much contact\*\* have you had in the last 6 months?

**\*\*Please note that a minimum of 3 sessions is recommended\*\***

---

---

---

4. Have you described the OLCHC program to the guest?  yes  no

5. Explain how you have prepared the guest for OLCHC. (Travel costs, things to bring, support required after program completion)

---

---

---

6. For guest safety we recommend a follow-up appointment within 2 weeks of completion of the program. Has an appointment been set to develop an aftercare plan with the guest?  yes  no

If yes, when? \_\_\_ / \_\_\_ / \_\_\_ If no, why not?

---

---

---

7. Are you in any way related to the guest being referred? If yes, please  yes  no  
Indicate your relationship to the guest (father, mother, brother, sister, in-law, cousin, etc).

---

---

---

8. Will this relationship affect confidentiality for the guest? If yes, please  yes  no  
Explain.

---

---

---



Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting

Part 3—Ormond Lake Cultural Healing Camp  
Pre-Admission Medical Assessment

**Please Print**

Client's Legal Name: \_\_\_\_\_  
Also Known as: \_\_\_\_\_  
Personal Health Number: \_\_\_\_\_  
Status Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
Referral Worker Name: \_\_\_\_\_  
Referral Worker Title: \_\_\_\_\_  
Referral Agency Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**Client Consent**

I, \_\_\_\_\_, hereby give my consent for Carrier Sekani Family Services Addictions Recovery Program to collect my medical information as a condition of attending Ormond Lake Cultural Healing Camp. I consent to my information being released by Dr \_\_\_\_\_ to the Addictions Recovery Program.

Participant's Signature \_\_\_\_\_  
Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_  
in the Province of British Columbia.

**TO THE PHYSICIAN OR NP:**

The client mentioned above is to be medically assessed as a requirement for participation in a treatment program at Ormond Lake Cultural Healing Camp for alcohol, drug, and inhalant abuse/dependency. The Addictions Recovery Program requires each client to have a complete physical examination prior to admission. Please include any relevant results from lab, operative reports or consultations including psychological or educational psychology reports. Activities that the client may participate in during their stay at camp include smudging ceremonies, sweat lodges, hiking, hunting, swimming and/or boating.



**Youth Intake Package**  
**Ormond Lake Cultural Healing Camp (OLCHC)**  
**Guest Intake and Goal Setting**

Client Name: \_\_\_\_\_

<b>9. Physical Examination</b>	<b>Normal</b>	<b>Abnormal</b>
Appearance	_____	_____
Ear / Nose / Throat	_____	_____
Hair / Skin / Nails	_____	_____
Lymphatic System	_____	_____
Musculoskeletal	_____	_____
Cardiovascular	_____	_____
Respiratory	_____	_____
CNS	_____	_____
Abdomen	_____	_____
Thyroid	_____	_____
Genito-Urinary	_____	_____

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

10. Please comment on any abnormalities in the functional or the physical examination.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

11. Does this client have a psychiatric history, clinical depression, other? Please comment.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Any problems prior to treatment that requires follow-up? Please describe.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

13. Do you have any comments, suggestions or insights that might be helpful in terms of the client being physically (moderate physical exercise) and mentally able to participate in group and/or one-on-one counseling (i.e. Hearing problems) and living in a remote location for a week's time? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

14. If any prescribed medications are required during the client's stay at camp, please list and briefly describe instructions for the client: \_\_\_\_\_  
 \_\_\_\_\_

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

Client Name: \_\_\_\_\_

**To the physician or NP: Clients wishing to attend Ormond Lake Cultural Healing Camp must be tested for TB prior to admittance to treatment. If the client does not have a TB test on record from the last 12 months, please assist the client in obtaining this test and then forward the results on to Addictions Recovery Program.**

15. Has the client undergone a TB test in the last 12 months?

If yes, were the results  positive  negative ?

Date of test: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If no, please refer the client to the appropriate nurse for testing. \*Carrier Sekani Family Services Community Health Nurses can provide TB Screening for Carrier clients.

**Declaration of Fitness**

I have examined the client and find him/her to be fit to attend Ormond Lake Cultural Healing Camp.  
 Fit  Unfit

\_\_\_\_\_  
Physician or NP signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

Clinic Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for assisting our guest with completing the application process  
to attend Ormond Lake Cultural Healing Camp.  
Please fax this form to CSFS Addictions Recovery Program confidential  
Fax line at 250-567-2533 or mail to  
ARP Intake Worker  
Box 1219  
Vanderhoof, BC, V0J 3A0**

**Youth Intake Package  
Ormond Lake Cultural Healing Camp (OLCHC)  
Guest Intake and Goal Setting**

**Completed Application Checklist**

- |                                     |                          |
|-------------------------------------|--------------------------|
| Part 1 Guest Information            | <input type="checkbox"/> |
| Signed House Rules                  | <input type="checkbox"/> |
| Consent to Attend and Participate   | <input type="checkbox"/> |
| Consent to Release Information      | <input type="checkbox"/> |
| Boat and Wildlife Disclaimer        | <input type="checkbox"/> |
| Waiver and Release                  | <input type="checkbox"/> |
| Part 2 Referral Worker's Assessment | <input type="checkbox"/> |
| Part 3 Medical Assessment           | <input type="checkbox"/> |

**All forms must be completed and received by the ARP Intake Worker a minimum of 4 weeks prior to the camp date.**

**Fax this completed form to our confidential fax line 250-567-2533.**

**Only completed forms will be processed.**