

Ormand Lake Healing Camp Pre-Admission Medical Assessment

Please Print

Client's Legal Name: _____

Also Known as: _____

Personal Health Number: _____

Status Number: _____

Date of Birth: _____ Phone # _____

Home Address: _____ Cell # _____

Referral Worker Name: _____

Referral Worker Title: _____ Phone # _____

Referral Agency Address: _____ Fax # _____



Consent

I, _____, hereby give my consent for CSFS Addictions Recovery Program to collect my medical information as a condition of attending Ormand Lake Healing Camp. I consent to my information being released by Dr _____ to the Addictions Recovery Program.

Participant's Signature _____

Dated this _____ day of _____ 200__ in the Province of British Columbia.

TO THE PHYSICIAN OR NP:

The aforementioned client is to be medically assessed as a requirement for participation in a treatment program at Ormand Lake Healing Camp for Alcohol, Drug, 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.

Client Name: _____

1. List any known drug used:

2. Is the client free of: Scabies Yes No

STD Yes No

Lice Yes No

3. Is the client a smoker? Yes No

4. Any allergies? Yes No

If yes, please list: _____

5. Describe medical conditions the client is self-managing:

6. Female client's date of last menstrual period: _____

Is the client pregnant? Yes No

If yes, when is the due date? _____

* OLHC will only accept pregnant clients in their 2nd trimester.

Client Name: _____

7. Any dietary restrictions? Yes No

If yes, please explain:

8. Functional Inquiry

Normal

Abnormal

Gastrointestinal

Genito-Urinary

Respiratory

Cardiac

Musculoskeletal

Hair / Skin / Nails

Blood / Lymphatic

Ear / Nose/ Throat

Suicide Ideation? Yes No

Date of last attempt: _____

9. Physical Examination

Normal

Abnormal

Appearance

Ear / Nose / Throat

Hair / Skin / Nails

Lymphatic System

Musculoskeletal

Cardiovascular

Respiratory

CNS

Abdomen

Thyroid

Genito-Urinary

Client Name: _____

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: _____

Client Name: _____

To the physician or NP: Clients wishing to attend Ormand Lake 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 this client and find him/her to be fit/not fit to attend Ormand Lake Healing Camp:

Fit Not Fit

Physician or NP Signature

Date

Physician or NP Name print

Office / clinic Address: _____

Thank you for assisting our clients with the process to attend Ormand Lake Healing Camp.

**Please fax this form to CSFS Addictions Recovery Program
confidential fax line 250-567-2533
or mail
ARP Intake Worker
Carrier Sekani Family Services
Box 1219
Vanderhoof, BC
V0J 3A0**