

# 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 <input type="checkbox"/>	No <input type="checkbox"/>
STD	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lice	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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:

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8. Functional Inquiry

Normal

Abnormal

Gastrointestinal

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Genito-Urinary

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Respiratory

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Cardiac

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Musculoskeletal

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Hair / Skin / Nails

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Blood / Lymphatic

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Ear / Nose/ Throat

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Suicide Ideation? Yes  No

Date of last attempt: \_\_\_\_\_

9. Physical Examination

Normal

Abnormal

Appearance

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Ear / Nose / Throat

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Hair / Skin / Nails

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Lymphatic System

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Musculoskeletal

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Cardiovascular

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Respiratory

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CNS

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Abdomen

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Thyroid

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Genito-Urinary

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

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

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

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

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

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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? \_\_\_\_\_

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

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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**