

Application for Treatment—Ormand Lake Cultural Healing Camp Family Camp 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 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 locked cabinets 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.

Please select which camp you would like to attend.

Families Camp June 22-28

Families Camp July 20-26

Families Camp Aug 31– Sept 6

****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 2 weeks (14 days) prior to attending

Thank you for applying to Ormand Lake Cultural Healing Camp.

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: _____ First name: _____

Birth date: ____/____/____ (dd/mm/yy) Age: ____ M F

Aboriginal Identity:

- Status
- Non-status
- Inuit
- Metis
- Other

Marital Status

- Single
- Common-law
- Married
- Divorced
- Separated
- Widowed

Address: _____ Phone: _____

_____ Cell: _____

_____ Message: _____

_____ Emergency Contact: _____

_____ Phone: _____

First Nation name: _____

Address: _____

Status Number: _____

Personal Health Number/BC Care Card #

Referral Worker's Name: _____

Referral Worker's Title: _____

Address of Organization: _____

Phone: _____ Fax: _____

Dependent Information Please Print

Number of children attending camp _____

Child #1

Last name: _____ First name: _____

Birth date: ____/____/____ (dd/mm/yy) Age: ____ M F

Any known allergies to food? Yes No

If yes, please list: _____

Any allergies to medication? Yes No

If yes, please list: _____

Is this child taking any medication? Yes No Please list
Medication Dosage Reason

<i>Medication</i>	<i>Dosage</i>	<i>Reason</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child #2

Last name: _____ First name: _____

Birth date: ____/____/____ (dd/mm/yy) Age: ____

Any known allergies to food? Yes No

If yes, please list: _____

Any allergies to medication? Yes No

If yes, please list: _____

Is this child taking any medication? Yes No Please list
Medication *Dosage* *Reason*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child #3

● Last name: _____ First name: _____

● Birth date: ____/____/____ (dd/mm/yy) Age: ____

● Any known allergies to food? Yes No

● If yes, please list: _____

Any allergies to medication? Yes No

If yes, please list: _____

Is this child taking any medication? Yes No Please list
Medication *Dosage* *Reason*

_____	_____	_____
_____	_____	_____
_____	_____	_____

Child #4

Last name: _____ First name: _____

Birth date: ____/____/____ (dd/mm/yy) Age: _____

Any known allergies to food? Yes No

If yes, please list: _____

Any allergies to medication? Yes No

If yes, please list: _____



Is this child taking any medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please list
<i>Medication</i>	<i>Dosage</i>		<i>Reason</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please use this space to tell us if your child(ren) have any special needs and requirements while at camp.



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 _____
- Arthritis
- Physical Impairment (circle) vision hearing mobility
- Hepatitis A B C (circle)
- Tuberculosis ~ TB Active Dormant
- Asthma
- Other: _____

2. Are you taking any medications? Yes No Please list.

<i>Medication</i>	<i>Dosage</i>	<i>Reason</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Do you have allergies to any medications? Yes No

If yes, please list:

4. Do you have any food allergies? Yes No

If yes, please list:

5. Have you ever been hospitalized as a result of an 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 were not listed?

Please explain.

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? Do you have an epi pen? Yes No

13. Are you pregnant? Due date: ____/____/____ Yes No

14. Do exercise regularly? Yes No

B. Emotional Needs

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

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

2. Have you ever attempted suicide? Yes No

3. Have you ever had suicidal thoughts? Yes No

4. Have you ever participated in groups before? Yes No

Please describe your experience.

5. Do you feel ready and willing to participate in intensive group work?

Yes No

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 you answered 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 for any mental illness?

- Bi-polar
- Schizophrenia
- Depression
- Other _____

What are you doing to stabilize this condition?

Do you have feelings of extreme sadness, depression, anxiety or panic attacks?

13. Are your children in care? MCFD?

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

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

15. Please describe 3 goals you have for yourself.

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.

3. Provide 2 peer supports you have.

Name: _____ Name: _____

Phone: _____ Phone: _____

4. Current Marital Status:

Single Common-law Married Separated
 Divorced Widowed

5. Family Status:

Couple Living Alone
 Extended Family Single Parent
 Living with family Living with friends
 Living with spouse Spouse & children

Number of dependent children (0-19 years of age): _____

6. Educational Status: (Check highest level of education completed)

Elementary (K-12) Graduated High School
 Trade School (culinary arts, carpentry) College (Diploma)
 University (Bachelor) Graduate (Masters, PhD)

7. Employment Status

Occupation: _____ Full time Part time
 F/T Seasonal P/T Seasonal Unemployed
 Retired Student Homemaker

Not in labor force due to disability

D. Spiritual/Cultural Needs

1. To which Nation do you belong?

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

E. Mental Needs

1. Have you ever attended a Residential School?

Yes No

Have your parents or grandparents?

Yes No

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

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"/> Elder's Support	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____

5. Is this support working for you? Explain.

Yes No

6. 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?

Michigan Alcohol Screening Test

The MAST Test is a simple, self scoring test that helps assess if you have a drinking problem. Please answer YES or NO to the following questions:

1. Do you feel that you are a normal drinker? (“normal” drink as much or less than most people)

Yes No score _____

2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?

Yes No score _____

3. Does any near relative or close friend ever worry or complain about your drinking?

Yes No score _____

4. Can you stop drinking without difficulty after one or two drinks?

Yes No score _____

5. Do you ever feel guilty about your drinking?

Yes No score _____

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?

Yes No score _____

7. Have you ever gotten into physical fights when drinking?

Yes No score _____

8. Has drinking ever created problems between you and a near relative or close friend?

Yes No score _____

9. Has any family member or close friend ever gone to anyone for help about your drinking?

Yes No score _____

10. Have you ever lost friends because of your drinking?

Yes No score _____

11. Have you ever gotten into trouble at work because of drinking?

Yes No score _____

12. Have you ever lost a job because of drinking?

Yes No score _____

13. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?

Yes No score _____

14. Do you drink before noon fairly often?

Yes No score _____

15. Have you ever been told you have liver trouble such as cirrhosis?

Yes No score _____

16. After heavy drinking have you ever had delirium tremens (D.Ts), severe shaking, visual or auditory (hearing) hallucinations?

Yes No score _____

17. Have you ever gone to anyone for help about your drinking?

Yes No score _____

18. Have you ever been hospitalized because of your drinking?

Yes No score _____

19. Has your drinking ever resulted in being hospitalized in a psychiatric ward?

Yes No score _____

20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?

Yes No score _____

21. Have you ever been arrested more than once for driving under the influence of alcohol?

Yes No score _____

22. Have you ever been arrested, even for a few hours because of other behavior while drinking?

(If yes, how many times _____?)

Yes No score _____

Scoring

Please score one point if you answered the following:

1. No
2. Yes
3. Yes
4. No
5. Yes
6. Yes

● 7. through 22. Yes



● Add up the scores and compare the following score card:

0-2 No apparent problem

3-5 Early or middle problem drinker

6 or more problem drinker

Drug Abuse Screening Test (DAST)

For the purposes of this screening test, drug abuse refers to:

1. The use of prescribed or "over the counter" drugs in excess of the directions, and
2. Any non-medical use of drugs.

Please circle the one response to each item that best describes how you have felt over the past 12 months.

1. Have you used drugs other than those required for medical reasons?

Yes No score _____

2. Have you abused prescription drugs?

Yes No score _____

3. Do you abuse more than one drug at a time?

Yes No score _____

4. Can you get through the week without using drugs?

Yes No score _____

5. Are you always able to stop using drugs when you want to?

Yes No score _____

6. Have you had "blackouts" or "flashbacks" as a result of drug use?

Yes No score _____

7. Do you ever feel bad or guilty about your drug use?

Yes No score _____

8. Does your spouse (or parents) ever complain about your involvement with drugs?

Yes No score _____

9. Has drug abuse created problems between you and your spouse or your parents?

Yes No score _____

10. Have you lost friends because of your use of drugs?

Yes No score _____

11. Have you neglected your family because of your use of drugs?

Yes No score _____

12. Have you been in trouble at work because of your use of drugs?

Yes No score _____

13. Have you lost a job because of drug abuse?

Yes No score _____

14. Have you gotten into fights when under the influence of drugs?

Yes No score _____

15. Have you engaged in illegal activities in order to obtain drugs?

Yes No score _____

16. Have you been arrested for possession of illegal drugs?

Yes No score _____

17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

Yes No score _____

18. Have you had medical problems as a result of your drug use (i.e. memory loss, hepatitis, convulsions, bleeding, etc...)?

Yes No score _____

19. Have you gone to anyone for help for a drug problem?

Yes No score _____

20. Have you been involved in a treatment program especially related to drug use?

Yes No score _____

This self test is scored by allocating 1 point to each "yes" answer—except for questions 4 and 5, where 1 point is allocated for each "no" answer and totaling the responses.

House Rules for Ormand Lake Cultural Healing Camp

As a participant of Ormand 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, 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 use of violence or intimidation other 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 if I leave the camp grounds and I will inform staff of where I will be going and when I will return.
- Any child under 19 years of age must be accompanied by a parent/guardian or chaperone.

House Rules Cont'

- 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 Ormand Lake Cultural Healing Camp House Rules.

Name (print) _____

Signature _____

● Date _____



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 confirmation of my understanding of the following points:

1. _____ I understand that if I do not have 2 weeks (14 full days) from ALCOHOL & drugs, I will be immediately discharged from the program.
2. _____ I understand an incomplete application and lack of supporting documentation delays in the processing of my application and confirmation of an intake date.
3. _____ I consent to the ARP Intake Worker contacting 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 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 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.

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.

Referral Worker's Name _____
 Title _____ Email _____
 Organization _____
 Address _____
 City _____ Postal Code _____
 Phone _____ Fax _____

Consent for the Release of Confidential Information cont'

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 _____ 200__ in the
Province of British Columbia.

Referral Worker's Signature _____

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

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.

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

Participants Signature _____

Witness Signature _____

Witness Name and Address _____

Waiver and Release

In consideration of acceptance of my application to attend CSFS Ormand 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.

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

Name (print) _____

Signature _____

Witness Signature _____

Witness Name and Address _____

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:

_____	_____
_____	_____
_____	_____

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

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

E. OLCHC Guest Assessment

1. Guest expresses a need to change his/her life situation and is willing to explore any past traumatic life experiences?

Yes No

2. Guest shows a willingness to participate in the following:

Follow-up in winter months with ARP?

Yes No

3. If alcohol or drugs is a problem for the guest, is the guest willing to abstain from alcohol or drugs for 14 days prior to attending OLCHC?

Yes No

4. Guest is capable of physically and mentally participating in routine and recreational activities?

Yes No

5. Guest is able and willing to be involved in intensive group and individual counseling activities?

Yes No

6. Guest is free of any appointments or obligations for the entire length of program such as doctor's appointments or court cases etc...

Yes No

****If the guest answers "No" to any of the above questions, he/she may not be ready for intense healing work at OLCHC. The following is recommended: 1. Refer to a community-based counselor for OLCHC preparation sessions; 2. reassess for readiness in 1-2 months; 3. contact the ARP program at CSFS for further assistance.****

F. Physical Needs

1. Does your guest have any medical issues? Please check all that apply.

- Heart Condition: angina, hypertension, surgery, pacemaker
- Cancer:
- Seizures, Epilepsy, Neurological concerns (circle)
- A learning style difference
- Diabetes
- Arthritis
- Physical Impairment—vision, hearing, mobility (circle)

Please explain: _____

- Tuberculosis (TB) active dormant (circle)

Asthma

Allergies Explain: _____

Other Explain: _____

2. Is your guest on any medications? Yes No

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

3. Does your guest have any food allergies? Yes No

Allergen	Mild	Moderate	Severe
_____	<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"/>
_____	<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
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Low Self Esteem	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Lack of trust	<input type="checkbox"/>	<input type="checkbox"/>
Verbal Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Self-Hatred	<input type="checkbox"/>	<input type="checkbox"/>
Victim of Rape	<input type="checkbox"/>	<input type="checkbox"/>
Victim of Gang Rape	<input type="checkbox"/>	<input type="checkbox"/>
Inability to express emotions	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Grief & loss	<input type="checkbox"/>	<input type="checkbox"/>
Confusion of sexual identity	<input type="checkbox"/>	<input type="checkbox"/>
Foster/adoption	<input type="checkbox"/>	<input type="checkbox"/>
Abandonment	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual abuse	<input type="checkbox"/>	<input type="checkbox"/>
Residential school	<input type="checkbox"/>	<input type="checkbox"/>
Cultural oppression	<input type="checkbox"/>	<input type="checkbox"/>
Boundaries	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
Prescription drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>
Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>

Issue	Present	Past
Bullying	<input type="checkbox"/>	<input type="checkbox"/>
Elder Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Rage	<input type="checkbox"/>	<input type="checkbox"/>

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

3. To your knowledge does the guest have a history of violent behaviour?

What kind of behaviour has been exhibited?

Property Damage Theft Assault

4. Does the guest have potential for violent or threatening behaviour?

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**)

6. 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? If no, please explain. Yes No

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

****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?

Part 3—Ormand 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 CSFS Addictions Recovery Program to collect my medical information as a condition of attending Ormand 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 _____ 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 Cultural 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? ____/____/____

OLCHC will only accept pregnant guests 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 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 Ormand 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 Ormand 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

Completed Application Checklist

- Part 1 Guest Information
- Signed House Rules
- Consent to Attend and Participate
- Consent to Release Information
- Boat and Wildlife Disclaimer
- Waiver and Release
- Part 2 Referral Worker's Assessment
- Part 3 Medical Assessment

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

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

Only completed forms will be processed.