



MUSKWA LAKE WELLNESS CAMP

REFERRAL FORM

Date: _____

PARTICIPANT INFORMATION

Name: _____
First Middle Last

Birth Date: _____ / _____ / _____ Age: _____ Gender: _____
Day Month Year

Status: ☐ Metis ☐ First Nation: _____ ☐ Non-Status ☐ Non-Indigenous

Address: _____

Phone: _____ Alt Phone: _____

Presenting Problem: _____

What substances are they using: _____

When is their most recent use: _____

Do you have any current or past mental health issues/concerns? _____

At this time do you hear voices or see people that others do not see? _____

Have you been prescribed any medication? Please list: _____

Do you have any criminal charges? (if so, list charges and upcoming court dates):

Are you physically able to safely take part in camp activities (daily chores, lifting etc.): _____

Treatment History:

Have you previously attended any treatment programs: ☐ Yes ☐ No

Where have you attended? _____

Was the program completed? ☐ Yes ☐ No

If no, please explain why: _____

Is there more information you would like to include:

Participant Signature

REFERRING PERSON

Name: _____
First *Last*

Profession: _____ Relation: _____

Address: _____

Phone: _____ Alt Phone: _____

Please return form to:

MLWC Coordinator
Health & Wellness Department, KML
Email: MLWC@kineepik.ca
Office: (306) 884-0009
Fax: (306) 884-0003