



INTAKE / ASSESSMENT - REFERRAL FORM



**NENQAYNI WELLNESS CENTRE SOCIETY**

BOX 2529 WILLIAMS LAKE, BC V2G 4P2

PHONE (250) 989-0301

1-888-668-4245

FAX (250) 989-0307

REFERALL AGENCY: \_\_\_\_\_

REFERRAL WORKER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

PROGRAM APPLYING FOR: *(Please check one)*

Family Drug & Alcohol Program ( 6 weeks) \_\_\_\_\_ Intake Coordinator Joan Evans  
Extension 206 email: [jevans@nenqayni.com](mailto:jevans@nenqayni.com)

Youth & Family Inhalant Program (6months) \_\_\_\_\_ Intake Coordinator Sharon Duffy  
Extension 223 email: [sduffy@nenqayni.com](mailto:sduffy@nenqayni.com)

May 2007



Today's date: \_\_\_\_\_

Referral worker name: \_\_\_\_\_

### CLIENT PROFILE

#### **1. IDENTIFICATION & PERSONAL INFORMATION**

Last Name: \_\_\_\_\_ *circle* Male or Female

First Name: \_\_\_\_\_ Known as: \_\_\_\_\_

Birth date: \_\_\_\_\_

Medical #: \_\_\_\_\_ 10 Digit Status #: \_\_\_\_\_

Ancestry/Nation: \_\_\_\_\_

S.I.N.#: \_\_\_\_\_

Language(s) used: \_\_\_\_\_

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

Home Phone Number: \_\_\_\_\_

Usual Occupation: <i>check</i>	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Permanent
	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired
	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Student
	<input type="checkbox"/> Job Training	<input type="checkbox"/> Temporary
	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Unemployed
	<input type="checkbox"/> Part-time	<input type="checkbox"/> Social Assistance

Income Source: <i>check</i>	<input type="checkbox"/> Income Assistance	<input type="checkbox"/> Family
	<input type="checkbox"/> Interest	<input type="checkbox"/> Job
	<input type="checkbox"/> None	<input type="checkbox"/> Other

#### **EMERGENCY CONTACTS**

List someone that you do not live with who may be contacted in an emergency if no-one at your home phone number is available.

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

Phone : \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

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

Phone : \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_



NENQAYNI WELLNESS CENTRE SOCIETY

Have you been involved with any of the following;

Please check

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Ministry of Children & Families | <input type="checkbox"/> Therapists  |
| <input type="checkbox"/> Court Worker                    | <input type="checkbox"/> Probation   |
| <input type="checkbox"/> Social Worker                   | <input type="checkbox"/> R.C.M.P.    |
| <input type="checkbox"/> Mental Health Worker            | <input type="checkbox"/> Other _____ |

Were you raised by your natural parents? *Circle* YES NO  
 If no, who raised you or has custody now? \_\_\_\_\_  
 Who are you currently living with -(please provide current address - page 2)

Parents only:  
 Have your children been apprehended? *Circle* YES NO  
 If yes, when? \_\_\_\_\_ And for how long? \_\_\_\_\_

Will your children be coming to treatment with you? *Circle* YES NO

Will the youth be under supervision of the ministry while in treatment?  
*Circle* YES NO

Details of supervision order (attach any documentation): \_\_\_\_\_

Social Worker: \_\_\_\_\_

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

Legal Guardian(s): \_\_\_\_\_ Phone: \_\_\_\_\_

**2.LEGAL HISTORY**

Have you been involved with the legal system? *Circle* YES NO

If yes check the appropriate involvement below;

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Bail     | <input type="checkbox"/> Probation               |
| <input type="checkbox"/> Parole   | <input type="checkbox"/> Under court order       |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Alcohol related offence |

Name of probation officer; \_\_\_\_\_

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

List any upcoming court dates: \_\_\_\_\_

Previous charges or convictions please list: \_\_\_\_\_  
\_\_\_\_\_



**3. SUBSTANCE ABUSE HISTORY**

Describe any alcohol, drug, or inhalant issues in the clients family of origin: \_\_\_\_\_

Are you attending treatment for chemical use: *circle* YES NO

If yes give details:

DRUG USED	AMOUNT USED PER DAY	AMOUNT USED PER MONTH	DATE LAST USED/COMMENTS
ALCOHOL (SPECIFY TYPE)			
MARIJUANA			
CRACK/COCAINE			
HEROIN			
INHALANTS (SPECIFY GAS, GLUE, OTHER..)			
PRESCRIPTION DRUGS (SPECIFY TYPE)			
INTERVENOUS DRUG (SPECIFY TYPE)			
OVER THE COUNTER DRUGS/NON PRESCRIPTION			
TOBACCO (CIGARETTES/CHEW)			
CAFFIENE			
OTHER			
OTHER			

Describe problems arising from your chemical use:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check those that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Chemical abuse chronic   | <input type="checkbox"/> Children apprehended     |
| <input type="checkbox"/> Experimenting with A & D | <input type="checkbox"/> Sexual abuse victim      |
| <input type="checkbox"/> Social use only          | <input type="checkbox"/> Family domestic violence |





**OUTSIDE RESOURCES**

*Please list any supportive persons (relatives and or counselors) and agencies in the community that you have contact with or could have contact with to help you be successful in treatment and as you continue to walk your healing journey after discharge. (Include phone numbers if known):*\_\_\_\_\_

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**SOCIAL FUNCTIONING**

Please check if the following issues have been a part of your life:

- Physical aggression or threatening behavior
- Verbal aggression/abuse
- Sexually aggressive behavior/promiscuous (verbal or physical)
- Difficulty following rules & regulations
- Withdrawal from substances (detoxification)
- Suicidal thoughts
- Suicide attempts
- Mental impairment
- FAS/FAE (Fetal Alcohol Syndrome/ Fetal Alcohol Effects)
- ADHD/ADD
- Depression
- Medical complications that may effect treatment
- Recklessness/ unhealthy risk taking
- Running away
- Co-dependant/Controlling
- Uncontrolled anger outbursts
- Criminal charges
- Other destructive behaviors ( vandalism/ arson - please specify below)
- self injury/ mutilation/ multiple piercing -*please give details*
- eating disorder - specify type\_\_\_\_\_

Comments:

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**RECOMMENDATIONS**

Please add further insights that you feel may assist the intake worker/treatment team in assessing for possible acceptance. Attach any supporting letters or documents.

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**PARENTAL / GUARDIAN  
CONSENT TO TREATMENT**

**I/we**, the parent(s) legal guardian(s) of \_\_\_\_\_ do hereby agree and consent to have the above named admitted to residential treatment at Nenqayni Wellness Centre, Williams Lake, British Columbia.

Possible start date: \_\_\_\_\_ *intake worker may provide dates*

Possible end date: \_\_\_\_\_

PRINT \_\_\_\_\_ Parent Guardian Name

\_\_\_\_\_ Parent Guardian Name

SIGNATURE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

**YOUTH CONSENT**

If I am accepted to Nenqayni Wellness Centre I understand that I will be expected to sign a "Treatment Agreement" within the first 48 hours. If I choose not to sign I may be released/discharged at the earliest convenience. I understand that arranging for an early discharge will be my referral workers responsibility although Nenqayni will ensure that safe and adequate arrangements have been completed where possible.

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_



**AUTHORIZATION TO RELEASE  
INFORMATION**

*Parent or guardian should complete this page:*

I \_\_\_\_\_ (print name) do hereby authorize  
Nenqayni Wellness Centre Society to obtain information about my child:

\_\_\_\_\_  
*name*

from court workers, parole or probation officers, social workers, medical  
or psychiatric practitioners, educators or other relevant professionals.

This consent is given from the date of signing and until 1 year from  
discharge or completion of program. I am also consenting for Nenqayni  
Wellness Centre to release such information, only as necessary, to other  
agencies, when required by law.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_



NENQAYNI WELLNESS CENTRE SOCIETY

11. MEDICAL PRE-ADMISSION MEDICAL ASSESSMENT

LEGAL CLIENT

NAME: \_\_\_\_\_

Known as (preferred name): \_\_\_\_\_

Medical Number: \_\_\_\_\_

Status Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

\_\_\_\_\_

Home Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Referral Agency/Contact Worker Name: \_\_\_\_\_

Referral Agency/Contact Worker Address: \_\_\_\_\_

Referral Agency/Contact Worker Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

CLIENT RELEASE:

I, \_\_\_\_\_ do hereby request and permit my physician, to release medical facts and assessment about myself, to NENQAYNI WELLNESS CENTRE SOCIETY and the above named referral agency. The photocopy of my signature on this form is as valid as the original.

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

TO THE PHYSICIAN:

The above mentioned client is to be medically assessed as a requirement for participation in a residential treatment program at NENQAYNI WELLNESS CENTRE, Williams Lake, BC for Alcohol/Drug/Inhalant Abuse/Dependency. NENQAYNI requires each client to have a complete physical examination prior to admission. Please include any relevant: lab results, operative reports or consultations, including psychological or educational psychology reports.



MEDICAL EXAMINATION

CLIENT NAME: \_\_\_\_\_

1. List any known drug used: \_\_\_\_\_  
\_\_\_\_\_

2. Any recent history of: *check* Scabies  YES  NO  
STD's  YES  NO  
Lice  YES  NO

3. Any psychiatric – suicidal ideation and/or attempts, clinical depression, other?

*circle* YES NO  
**If yes, please comment on #12.**

4. Any history of seizures? *circle* YES NO  
If yes please elaborate: \_\_\_\_\_  
\_\_\_\_\_

5. Any Allergies? *circle* YES NO  
If yes please list: \_\_\_\_\_  
\_\_\_\_\_

6. Females; Date of last menstrual period: \_\_\_\_\_

Is client pregnant  YES  NO  
 GRAVIDA  PARA

If yes, how many weeks? \_\_\_\_\_

7. Any dietary restrictions? *circle* YES NO  
If yes please list: \_\_\_\_\_  
\_\_\_\_\_



CLIENT NAME: \_\_\_\_\_

8. FUNCTIONAL INQUIRY

<i>specify</i>	NORMAL	ABNORMAL
GASTROINTESTINAL	_____	_____
GENITO-URINARY	_____	_____
RESPIRATORY	_____	_____
CARDIAC	_____	_____
MUSCULOSKELETAL	_____	_____
HAIR/ SKIN/ NAILS	_____	_____
BLOOD/ LYMPHATIC	_____	_____
EAR/ NOSE/ THROAT	_____	_____

9. **PHYSICAL EXAMINATION:**

	NORMAL	ABNORMAL
APPEARANCE	_____	_____
EAR/ NOSE/ THROAT	_____	_____
HAIR/ SKIN/ NAILS	_____	_____
RETICULOENDOTHELIAL	_____	_____
MUSCULOSKELETAL	_____	_____
CARDIOVASCULAR	_____	_____
RESPIRATORY	_____	_____
CNS	_____	_____
ABDOMEN	_____	_____
THYROID	_____	_____
GENITO-URINARY	_____	_____



CLIENT NAME: \_\_\_\_\_

10. HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_ BP: \_\_\_\_\_

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

\_\_\_\_\_

12. Any problems prior to treatment that require 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 residence for the duration of the program? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. If any prescribed medications are required during treatment please list describe briefly instructions for the client: \_\_\_\_\_

\_\_\_\_\_

**FOR MINORS ONLY**

15. Has a prenatal record and assessment record been completed for the mother of this child/youth?

*Circle* YES NO UNKNOWN

16. If yes, what risk factor (number) was assigned? \_\_\_\_\_

17. Briefly explain the nature of any identified risk factors (i.e. alcohol, drugs during pregnancy) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



NENQAYNI WELLNESS CENTRE SOCIETY

CLIENT NAME: \_\_\_\_\_

18. Was the Post-natal Follow-up done for this child? *circle* YES NO

If yes, briefly explain the findings and present health status of the youth. \_\_\_\_\_

\_\_\_\_\_

I have examined this client and find him/her to be fit/not fit to attend treatment:

\_\_\_\_\_ FIT \_\_\_\_\_ NOT FIT

\_\_\_\_\_  
*Physicians Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physicians Name PRINT*

Office/clinic Address: \_\_\_\_\_

\_\_\_\_\_

***To the physician: Please refer the remainder of this medical assessment package to the appropriate nurse for completion.***



NENQAYNI WELLNESS CENTRE SOCIETY

CURRENT PRESCRIBED MEDICATION

DATE: \_\_\_\_\_

NAME: _____		DOB: _____	
PROGRAM: _____ FAMILY DRUG & ALCOHOL PROGRAM - <i>FADP</i> _____ YOUTH & FAMILY INHALANT PROGRAM - <i>YFIP</i>			
MEDICAL NO.: _____		STATUS NO.: _____	
ALLERGIES: _____			
CURRENT PRESCRIBED MEDICATION(S) – <i>LIST EACH SEPERATELY</i>			
1. _____			
START DATE OF PRESCRIPTION: _____			
END DATE OF PRESCRIPTION: _____			
DOCTOR PRESCRIBING: _____			
PHONE NUMBER: _____			
PHARMACY DISPENSED AT: _____			
PHONE NUMBER: _____			
INSTRUCTIONS FOR USE: _____			
_____			
2. _____			
START DATE OF PRESCRIPTION: _____			
END DATE OF PRESCRIPTION: _____			
DOCTOR PRESCRIBING: _____			
PHONE NUMBER: _____			
PHARMACY DISPENSED AT: _____			
PHONE NUMBER: _____			
INSTRUCTIONS FOR USE: _____			
_____			
3. _____			
START DATE OF PRESCRIPTION: _____			
END DATE OF PRESCRIPTION: _____			
DOCTOR PRESCRIBING: _____			
PHONE NUMBER: _____			
PHARMACY DISPENSED AT: _____			
PHONE NUMBER: _____			
INSTRUCTIONS FOR USE: _____			
_____			
OFFICE USE ONLY		DATE RECEIVED: _____	
CLINICAL REVIEW DATE: _____		SENT TO PHARMACY DATE: _____	
REVIEWED WITH CLIENT AT ARRIVAL: _____			
REVIEWED AT DISCHARGE: _____			
COMMENTS: _____			
_____			
_____			



CLIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

## TB SCREEN

**To the nurse:** Please ensure that the following is filled out as completely as possible. Include copies of any relevant records.

*As indicated on the assessment and referral package page ii, TB testing is required before participating in a residential treatment program. Please ensure that TB testing has been completed and that the results are forwarded to the treatment centre.*

Has a Tuberculosis screening test been done for this client?

Circle YES NO

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

Results: NEGATIVE \_\_\_\_\_ POSITIVE \_\_\_\_\_ \*(a positive result requires x-ray)

Chest X-Ray: circle YES NO

Interpretation: \_\_\_\_\_

Prophylaxis: \_\_\_\_\_ Date Started: \_\_\_\_\_

Has this client had any or all hepatitis B Immunizations? YES NO

If yes, how many? \_\_\_\_\_

Next due: \_\_\_\_\_

### **FOR DEPENDANT CHILDREN**

Was the post-natal follow up done for this child? YES NO

If yes, briefly explain the findings, and present health status of the youth.

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

Is there an immunization schedule on file for this child? YES NO

If yes, what is presently required and will this be administered prior to entry into the wellness program?

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



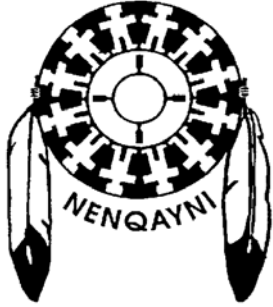
NENQAYNI WELLNESS CENTRE SOCIETY

**SCHOOL INFORMATION**

YOUTH NAME: <i>First</i> <i>middle</i> <i>last</i>
HOME ADDRESS:
BIRTHDATE:
PLACE OF BIRTH:
TRIBAL HERITAGE:
STATUS NUMBER:
MEDICAL NUMBER:
PARENT(S) or GUARDIAN(S) NAME(S): <i>circle one</i>
NAME OF LAST SCHOOL ATTENDED:
DATE LAST ATTENDED:
SCHOOL PHONE:
TEACHER NAME:
PRINCIPAL NAME:
<i>Circle</i> ELEMENTARY JUNIOR HIGH SENIOR HIGH ALTERNATIVE SCHOOL CORRESPONDANCE OTHER
GRADE LEVEL:
SCHOOL ON or OFF RESERVE? <i>Circle</i> ON OFF
COMMENTS:



NENQAYNI WELLNESS CENTRE SOCIETY



**YOUTH & FAMILY SCHOOL PROGRAMS  
Cariboo-Chilcotin School District #27**

**NENQAYNI WELLNESS CENTRE SOCIETY**

P.O. Box 2529, Williams Lake, BC V2G 4P2  
Phone (250) 989-0301/ Fax (250) 989-0307

**FREEDOM OF INFORMATION AND PROTECTION  
OF PRIVACY ACT  
PARENT/GUARDIAN CONSENT FORM**

To ensure that we comply with the Provincial Governments Freedom of Information and protection of Privacy legislation, we ask that you please read the following information carefully and return this completed form to Nenqayni Youth Program School as soon as possible.

**1. ACCESS TO INFORMATION BY:**

- **SCHOOL PERSONNEL**
- **NENQAYNI YOUTH PROGRAM STAFF**

The school will normally make the parent/guardians name, telephone number, and mailing address, as well as the child's name and grade, available to the school personnel/Nenqayni Staff for the purposes of contacting parent to consult them directly about school issues or to plan school-related activities. Your personal information will not be disclosed to anyone for business or commercial purposes.

**2. PUBLISHING OF STUDENTS' PICTURES, NAMES OR COMMENTS IN:**

- **PUBLIC MEDIA**
- **SCHOOL BASED-VIDEOS, NEWSLETTER, YEARBOOKS, ETC.**

At times various educational, sports, and cultural events are publicized by the media or by the school. The publishing of students' photographs, names, or comments, in the media or school based publications, adds to the community life of our school. Permission is required.

\_\_\_\_\_ **YES** I give my permission for the school to release my personal information for the purposes consistent with all of the above.

\_\_\_\_\_ **NO** I do not want personal information released for purposes consistent with all of the above.

**THIS PERMISSION WILL BE IN EFFECT FOR THE TIME YOUR CHILD IS ENROLLED IN THIS SCHOOL, UNLESS YOU ADVISE OTHERWISE.**

\_\_\_\_\_  
Child's Name (*please print*)

\_\_\_\_\_  
Parent/Guardian's Name (*please print*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Guardian Signature



**YOUTH & FAMILY INHALANT PROGRAM**  
*Nenqayni Wellness Centre*

**AWOL PROCEDURES FORM**

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

Alias' or nicknames : \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

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

Status No. \_\_\_\_\_

Medical No. \_\_\_\_\_

Referral Worker: \_\_\_\_\_

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

<b>PHYSICAL DESCRIPTION:</b>	
Hair Color: _____	Tattoos: _____
Eyes: _____	_____
Height: _____	Scars: _____
Weight: _____	Piercing(s): _____

Are there any Court Orders currently in effect? *Circle* YES NO

***If yes, attach PROBATION ORDERS!***

Probation Officer Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

After hours contact: \_\_\_\_\_



**NOTIFICATION PROCEDURE**

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

The Nenqayni Wellness Centre - Youth & Family Inhalant Program will make every attempt to ensure the safety of the above named client at all times. In the event of an AWOL the treatment staff may allow sufficient time for the above named to return to the centre if the circumstances around their leaving is such that it may warrant a "cooling off" period rather than an "AWOL Report". Any unplanned leave that is longer than 4 hours will be considered "AWOL" and will be followed up by a formal report to referral worker/probation officer.

***When staff assess that the youth is at sufficient risk a report will be made to the RCMP, any breach of probation will be reported.***

**REFERRAL WORKER**

In the event of an AWOL I \_\_\_\_\_ would like to be notified; (Referral Worker)

\_\_\_\_\_ 12 Hours

\_\_\_\_\_ 24 Hours

Referral Worker Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## **PARENTAL/GUARDIAN PARTICIPATION FORM**

Family participation in the Nenqayni Wellness Centre - Youth & Family Inhalant Program is recommended for best treatment outcome. A supportive family member should plan to attend near the end of the youths treatment cycle. The length of time for the family participation may be 6 weeks in our regular Family Drug and Alcohol Program or a different amount of time that is agreed upon between the participants and Nenqayni staff.

I, \_\_\_\_\_ and  
*Name of parent or participant*

I, \_\_\_\_\_ agree to participate  
*Name of parent or participant*

with my child in the Youth & Family Inhalant Program at Nenqayni Treatment Centre when requested by the treatment team.

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**\* Note; In the event that family participation cannot occur, foster parent or other supportive persons participation/involvement may be requested. Only those that can agree to commit to participation should sign this form.**



## COMMITMENT TO CARE AGREEMENT

**Dear Referral Worker;**

Attached to this application form you should find a list of items that clients may bring when coming to treatment. Some items are required, some are optional and please note the items that are not allowed and will be confiscated - locked up/sent home or otherwise disposed of.

Youth that do not bring with them the "required items" will need to obtain them so that they may participate fully in some of the program activities. Also please note that your client may outgrow some clothing while in treatment. Shoes commonly get worn out or outgrown and may need to be replaced during the treatment period.

We are asking that you ensure funds may be obtained if necessary for any needed items during treatment. If items are required the Wellness Centre will call you to request funding. You may try to obtain funding from the family directly or secure funding by other means. When the necessary funds are obtained we ask that a cheque be sent. Please make cheque's payable to *NENQAYNI WELLNESS CENTRE SOCIETY* - not payable to the youth, but please ensure the youths name is attached in some way to the cheque so that we know who it is for!

Sign this form and return with the application package, this will confirm that you are aware of the possible need to arrange funding for required items during treatment.

I \_\_\_\_\_ agree to arrange funds to purchase necessary items for my client while they are in the program.

Signature: \_\_\_\_\_

Position: \_\_\_\_\_

Date: \_\_\_\_\_



**YOUTH & FAMILY INHALANT PROGRAM (YFIP)**

**ITEMS TO BRING.....**

**CLOTHING:**

- |  |   |
|--|---|
| <input type="checkbox"/> Pants-jeans/track pants | <input type="checkbox"/> Shoes/runners                |
| <input type="checkbox"/> T-shirts                | <input type="checkbox"/> Slippers                     |
| <input type="checkbox"/> Sweatshirt              | <input type="checkbox"/> Housecoat                    |
| <input type="checkbox"/> Sweater                 | <input type="checkbox"/> Pajamas                      |
| <input type="checkbox"/> Socks                   | <input type="checkbox"/> Gym clothes(shorts, t-shirt) |
| <input type="checkbox"/> Underclothing           | <input type="checkbox"/> Bathing suit (required)      |
| <input type="checkbox"/> Jacket                  |   |

**WASHER AND DRYER ARE AVIALABLE FOR USE**

**SEASONAL:**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Winter coat     | <input type="checkbox"/> Scarf        |
| <input type="checkbox"/> Mittens, gloves | <input type="checkbox"/> Hat(toque)   |
| <input type="checkbox"/> Winter boots    | <input type="checkbox"/> Rubber boots |

**TOILETRIES & PERSONAL ITEMS:**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Toothbrush  | <input type="checkbox"/> Hairbrush             |
| <input type="checkbox"/> Toothpaste  | <input type="checkbox"/> Comb                  |
| <input type="checkbox"/> Deodorant   | <input type="checkbox"/> Female Personal items |
| <input type="checkbox"/> Shampoo     | <input type="checkbox"/> Hand cream (lotion)   |
| <input type="checkbox"/> Conditioner |  |

**DO NOT BRING ANY OF THE FOLLOWING RESTRICTED ITEMS:** Aerosols of any type, hairspray, mouth wash, nail polish, polish remover, razor blades, perfumes, matches, lighters and any sharp items or items containing alcohol. No stereo's or personal CD players.

***\*LUGGAGE IS SEARCHED UPON PROGRAM ENTRY\****

***If restricted items are found or turned in at program entry the items will be sent home or disposed of immediately.***

**YOU MAY WISH TO BRING:**

- |  |   |
|--|---|
| <input type="checkbox"/> Favorite stuffed animal                             | <input type="checkbox"/> Pictures from home(no glass in frames) |
| <input type="checkbox"/> A cuddly blanket                                    | <input type="checkbox"/> Books/ magazines                       |
| <input type="checkbox"/> Items that will help you share your culture with us |   |

**CARE PACKAGES THAT ARE RECEIVED DURING TREATMENT  
WILL BE SEARCHED AND  
RESTRICTED ITEMS WILL BE DISPOSED OF OR SENT HOME**

**Nenqayni Wellness Centre Society Box 2529, Williams Lake, BC V2G 4P2  
Phone:(250) 989-0301 Fax: (250) 989-0307**



# MAP - Where in the world is Nenqayni?

**Nenqayni Wellness Centre**  
**Williams Lake, BC**  
**(250)989-0301**  
**1-888-668-4245**  
**2 Residential Programs**  
**Family Drug & Alcohol Program (6-weeks)**  
**Youth & Family Inhalant Program (5 ½ months)**

Quesnel to Nenqayni	103 km
Williams Lake to Nenqayni	21 km
Prince George to Nenqayni	205 km
100 Mile House to Williams Lake	91 km

