# Referral Guidelines

## PROGRAM DESCRIPTION:

For more information, please click here or visit: www.icmha.ca/grow

- Grow is a community-based adult mental health program offering psychosocial rehabilitation via groups and one-to-one coaching. Most services are in-person either at the Grow Program (125 Skinner St.) or at community locations, while some services may be virtual.
- You will be assigned a Recovery Coach who will oversee your involvement in the program, with maximum time in the program being 1 year.

## GUIDELINES:

- Participant is an adult, 19 years and above
- Participant lives in Vancouver Island's Capital Regional District, including southern gulf islands
- Participant is experiencing mental health issues and are seeking to work on their recovery they may also be experiencing additional substance use issues.
- Participant is willing to participate in group or 1:1 mental health recovery work.

We would like all participants to receive the best possible experience. Unfortunately, you may have to miss group or 1:1 sessions if they are:

- Experiencing a deterioration of their mental health. We will support them to get the right help
- Actively suicidal or at risk of harm to themselves or others
- Actively using substances before, or during groups. We do not need participants to be abstinent but they do need to be able to safely participate in programming

If we are not a good fit for you we will help refer you to other community resources.

Date of Referral: _____

***What is your name?*** _____ Preferred Pronoun: _____

Last Name First Name

DOB: _____ Phone: _____Okay/safe to leave a voicemail?_____

Email: _____

Preferred method of contact: Text____ Email_____ Phone___

# Referral Form

Other (Please explain):_____

Address: _____
Street City Postal Code

Emergency Contact: _____ Phone: _____
Name Relationship

***Who is making this referral?***

☐Self-referral ☐GP ☐Psychiatrist ☐Case Manager ☐Social Worker ☐OT ☐Support Worker

☐Other_____

Referrers' details (if applicable): _____
Name Role Clinic/Program Name

Phone: _____ Email: _____

Do you have any additional Supports?

_____ Phone: _____
Name Type of support

***MEDICAL & SAFETY INFORMATION***

Presenting Mental Health Issue(s): _____

Do you have any Physical/Cognitive Issue(s)? _____

Have you experienced Psychiatric hospitalization in the last year?_____

What would you like us to know about this if anything?

_____

| | | |
|---|---|---|
| Are you currently at risk of suicide/self-harm? | ☐ Yes<br>☐ No | Details: |
| Are you currently at risk of harming others? | ☐ Yes<br>☐ No | Details: |
| Do you use substances? (past or present)? | ☐ Yes<br>☐ No | Details: |

Is there anything else about your health that you would like to share with us?

_____

# Referral Form

### *Programs*

Are you attending any other programs or been referred to other services?

Details: _____

| What are your goals for the Grow Program | | Method of Service |
|---|---|---|
| ☐ Weekly Structure<br>☐ Coping Skills<br>☐ Lifestyle Habits (e.g., sleep, physical activity, diet)<br>☐ Healthy Thinking<br>☐ Social Connection<br>☐ Other: | ☐ Community Connection<br>☐ Volunteering<br>☐ Recreation<br>☐ Mental Health Programming | ☐ Groups<br>☐ 1:1 Coaching<br>☐ Both |

Thank you for filling out this referral, if you have any questions please contact
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