

## PROGRAM DESCRIPTION:

For more information, please click here or visit: [www.icmha.ca/grow](http://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.
- Clients will be assigned to a Recovery Coach who will oversee their involvement in the program, with maximum time in the program being 1 year.
- Grow Program does not have access to PowerChart or clinic notes, so we ask that referrers please fax relevant notes and Safety Plans along with the referral.

ADMISSION GUIDELINES:	EXCLUSION GUIDELINES:
<ul style="list-style-type: none"> <li>• Client is an adult, 19 years and above</li> <li>• Client lives in Vancouver Island's Capital Regional District, including southern gulf islands</li> <li>• Client is experiencing a worsening of symptoms due to a mental health issue that makes it difficult to participate in the greater community</li> <li>• Client has at least one professional support for mental health follow-up (psychiatrist, GP or regular walk-in clinic doctor, case manager, counsellor, psychologist, occupational therapist, support worker, etc.)</li> <li>• Client is cognitively/physically capable and willing to participate in a suggested Grow treatment plan</li> </ul>	<p>We would like all clients to receive the best possible care. Unfortunately, the Grow Program is not the best option for a client who is:</p> <ul style="list-style-type: none"> <li>• In an acute phase of their mental health recovery</li> <li>• Actively suicidal or at risk to harm others</li> <li>• Only wanting long-term support (i.e., longer than 1 year)</li> <li>• Engaging in active substance abuse</li> <li>• Is not cognitively/physically capable or willing to participate in a suggested Grow treatment plan</li> </ul> <p>If needed, we can provide suggestions for programs/resources that would better serve the client.</p>



# Referral Form



Date of Referral: \_\_\_\_\_

**CLIENT INFO:** \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_  
Last Name First Name

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
MM/DD/YY

Address: \_\_\_\_\_  
Street City Postal Code

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name Relationship

### PROFESSIONAL SUPPORT

Referring Clinician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name Role Clinic/Program Name

GP or  Walk-in Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name Clinic Name

Psychiatrist/Case Manager/Counsellor/OT/SW/Psychologist/Support Worker:  
\_\_\_\_\_  
Name Role Clinic/Program Name Phone: \_\_\_\_\_

### MEDICAL & SAFETY INFORMATION

Presenting Mental Health Issue(s): \_\_\_\_\_

Relevant Physical/Cognitive Issue(s): \_\_\_\_\_

Most Recent Psychiatric Hospitalization: \_\_\_\_\_  
Date Range Reason

Current risk of suicide/self-harm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Past suicide attempts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Current risk of harm to others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Substance Use (past or present)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:

### PSYCHOSOCIAL REHABILITATION

Concurrent Programming: \_\_\_\_\_

Client Goals for the Grow Program		Method of Service
<input type="checkbox"/> Weekly Structure <input type="checkbox"/> Coping Skills <input type="checkbox"/> Lifestyle Habits (e.g., sleep, physical activity, diet) <input type="checkbox"/> Healthy Thinking <input type="checkbox"/> Social Connection <input type="checkbox"/> Other:	<input type="checkbox"/> Community Connection <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Volunteering <input type="checkbox"/> Recreation Centre <input type="checkbox"/> Further Mental Health Programming	<input type="checkbox"/> Groups <input type="checkbox"/> 1:1 Coaching <input type="checkbox"/> Both

Signature of Referring Clinician: \_\_\_\_\_