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.
- 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:
• Client is an adult, 19 years and above • Client lives in Vancouver Island's Capital Regional District, including southern gulf islands • Client is experiencing a worsening of symptoms due to a mental health issue that makes it difficult to participate in the greater community • 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.) • Client is cognitively/physically capable and willing to participate in a suggested Grow treatment plan	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: • In an acute phase of their mental health recovery • Actively suicidal or at risk to harm others • Only wanting long-term support (i.e., longer than 1 year) • Actively using substances before, or during groups • Is not cognitively/physically capable or willing to participate in a suggested Grow support plan If needed, we can provide suggestions for programs/resources that would better serve the client.

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 (if applicable): _____
Name Role Clinic/Program Name

Phone: _____ Email: _____

Additional Referring Clinician:

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

_____ Phone: _____
Name Role Clinic/Program Name

MEDICAL & SAFETY INFORMATION

Presenting Mental Health Challenge(s): _____

Relevant Physical/Cognitive Challenge(s): _____

Most Recent Psychiatric Hospitalization: _____
Date Range Reason

Current risk of suicide/self-harm?	☐ Yes ☐ No	Details:
Current risk of harm to others?	☐ Yes ☐ No	Details:
Substance Use (past or present)?	☐ Yes ☐ No	Details:

PSYCHOSOCIAL REHABILITATION

Concurrent Programming: _____

Client Goals for the Grow Program	**Method of Service**

Please return or fax, attn: *Grow* | 125 Skinner Street Victoria BC V9A 6X4 | Fax: 250-389-1263

Referral Form

☐ Weekly Structure ☐ Coping Skills ☐ Lifestyle Habits (e.g., sleep, physical activity, diet) ☐ Healthy Thinking ☐ Social Connection ☐ Other:	☐ Community Connection ☐ Volunteering ☐ Recreation Centre ☐ Further Mental Health Programming	☐ Groups ☐ 1:1 Coaching ☐ Both