Networks

Referral Form

ISLAND COMMUNITY MENTAL HEALTH

PROGRAM DESCRIPTION:

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

- Networks is a community-based adult mental health program offering Education and Employment support via one-to-one coaching. Coaches can meet with you in the community or at our Skinner Street location.
- You will be assigned an employment or education 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 wanting to return to work and/or education.

We would like all participants to receive the best possible experience. Unfortunately, you may not be able to receive services if:

- 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 appointments. 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.

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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___

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?_____

Programs

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

Details: _____

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

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

_____

EDUCATION AND EMPLOYMENT

1. What are your goals for Education / Employment? Why do you want Education / Employment now?

_____

_____

_____

2. Are you interested in gaining more education to advance your career goals?

_____

_____

_____

3. What are some of your strengths? (Experience, training, personality, supports, etc.)

_____

_____

_____

4. What would you say are your biggest barriers to attending school or working?

_____

_____

_____

5. What type of Education / Employment do you think would be a good match? Why?

_____

_____

_____

Thank you for filling out this referral, if you have any questions please contact
Paula Greene
PSR Program Manager
Paula.greene@icmha.ca/ 250.389.1211 Ext: 128