Referral Guidelines

PROGRAM DESCRIPTION:

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

- The Island Community Mental Health Peer Supported Groups program is designed by peers, for peers.
- Each group focuses on community and connection with fellow peers while participating in fun activities such as cooking and art.
- Most services are in-person either at the Grow Program Office at 125 Skinner St, or at community locations, while some services may be virtual.

ADMISSION GUIDELINES:	REASONS FOR MISSING GROUPS:
• Participant is an adult, aged 19 years or above • Participant lives in Vancouver Island's Capital Regional District, including southern Gulf Islands • Participant is in recovery and comfortable in a group setting	We would like all participants to have the best possible experience. Unfortunately, participants may have to miss group sessions if they are: • In an acute phase of their mental health recovery • Actively suicidal or at risk to harm others • Actively using substances before, or during the group sessions • Unwilling, or unable to participate cognitively or physically If needed, we can provide suggestions for programs/resources that would better serve the client.

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

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: _____

☐ GP or ☐ Walk-in Doctor: _____ Phone: _____
Name Clinic Name

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:

INTEREST IN ACTIVITIES

Are you involved in any other programming? _____

Client Goals for the PEERS Program	
☐ Book Club ☐ Art ☐ Goal Setting ☐ Cooking	☐ Peer Support Training ☐ Exercise/Fitness ☐ Community Connection ☐ Social Groups

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ISLAND COMMUNITY MENTAL HEALTH

MENTAL HEALTH INFORMATION

To provide you with the best possible support, what should we know about your mental health condition(s)?

_____
_____
_____
_____

Relevant Physical/Cognitive Challenge(s):

_____
_____
_____
_____

Is there anything else you would like to share at this time?:

_____
_____
_____
_____

Thank you for completing this form.

Signature of Participant: _____
Signature of Peer Support Facilitator: _____

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