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 PEER support workers (people with lived and living experience), for peers.
- Each group focuses on community and connection providing space for activities such as cooking and art.
- Most services are in-person either at the Grow Program Office at 125 Skinner St, while some services may be virtual.

Guidelines	
• 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 mental health recovery and may have an additional substance use issue and is comfortable in a group setting	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.

Referral Form

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

To provide you with the best possible support what should we know about your Mental Health? ____

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?____________________________

____

Referral Form

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?

____

Programs

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

Details: ____

Client Goals for the PEERS Program	
☐ Social/Community Connection ☐ Art ☐ Goal Setting ☐ Cooking	☐ Peer Support Training ☐ Exercise/Fitness ☐ One – to –One support

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

Referral Form