ISLAND COMMUNITY MENTAL HEALTH

Island Community Mental Health

PSR Programs Referral

GUIDELINES:	
• You are an adult, 19 years and above • You live in Vancouver Island's Capital Regional District, including Southern Gulf Islands • You are experiencing concerns with your mental health and are seeking support in your recovery • You are willing to participate in group or 1:1 mental health recovery work If ICMH programs are not a good fit for you right now we will help refer you to other community resources.	We would like all participants to receive the best possible experience. Unfortunately, you may have to miss group or 1:1 sessions if you are: • Experiencing a deterioration of your mental health. We will support you to get the right help • Actively suicidal or at risk of harm to yourself or others • Actively using substances before, or during groups. We do not need you to be abstinent but you do need to be able to safely participate in programming

Referrals can be submitted in the following ways:

Email: icmha.referrals@islandhealth.ca

Fax: *250-389-1263*

In person at 125 Skinner St. reception. We can also assist you to complete the referral!

For all inquiries about referrals or program details, please contact PSR Program Manager:

Krysten O'Coffey krysten.ocoffey@icmha.ca 250.389.1211 Ext: 128

Please note: Wait times vary by program and current community need.

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Date: _____

What is your name? _____ (Last Name) _____ (First Name) Preferred pronoun: _____

DOB: _____ Phone: _____ Okay/safe to leave a voicemail? _____
Email: _____

Preferred method of contact: Text ☐ Email ☐ Phone ☐ Other ☐ _____

Address: _____ (Street) _____ (City) _____ (Postal Code)

Which programs/services are you interested in? (visit IMCHA.ca for program details)

Seniors Support Network
- ☐ Crafts (all ages, 19+)
- ☐ Coffee and Chat (all ages 19+)
- ☐ Coffee and Chat (seniors only)
- ☐ Bridging Wednesdays
- ☐ Games day (all ages, 19+)

Networks Education
- ☐ Accommodations/accessibility
- ☐ High school upgrading with Camosun
- ☐ Info re: grants, bursaries, funding options
- ☐ Info re: certificates, diplomas, degrees
- Study skills coaching

Networks Employment
- ☐ Resume/Cover letter building
- ☐ Job search support
- ☐ Interview prep
- ☐ Action-oriented career exploration
- ☐ Volunteering

GROW
- ☐ Journaling
- ☐ Mindfulness
- ☐ CBT
- ☐ Emotional Wellness
- ☐ Anxiety Group
- ☐ Goal Setting (Virtual)
- ☐ Yoga
- ☐ 1:1 Recovery Coaching
- ☐ Open art studio*
- ☐ Open computer lab
- ☐ Men's group*
- ☐ Women's group*
- ☐ Queer group*
- ☐ Talk & Step*
- ☐ Lifestyle & Wellness talks

*groups marked with an asterisks are co-facilitated by a Grow Coach and a Peer Support Worker

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Who is making this referral? Please Choose One

Referrers' details (if applicable): Name | Role | Clinic/Program Name

Phone: Email:

☐ Check this box if you consent for us to communicate with the above named person about your referral. You do not have to consent to receive services.

Goals and Support

What are you hoping to get out of attending programming or working with a coach? Do you have recovery, employment, or educational goals you'd like us to know? The more you share, the better we can prepare for our work together.

How is your mental health right now? Is your mental health a barrier to you meeting your goals?

What does your support system look like? Do you attend other programs?

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Medical and Safety Information

These questions speak to your current experience of safety and stability both personally and in group settings. It helps us better plan with you for a successful experience that meets your needs.

Do you have any physical or cognitive concerns that may require accommodation in order for you to participate in programming at ICMH?

Have you experienced a psychiatric hospitalization in the last year? What would you like us to know about this, if anything?

Is there anyone in your support system that you would like us to speak to with regards to your mental health, your needs, or how to best support you?

Name	Role/Relationship	phone number	email address

Name	Role/Relationship	phone number	email address

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 you'd like us to know that we haven't covered?

Thank you for your referral!