

Please select ALL that apply:

- WELLNESS DEVELOPMENT CENTRE (WDC)
- PEER SUPPORT: GROUP  OR 1 TO 1
- KITCHEN CONNECTIONS PROGRAM
- WELLNESS RECOVERY ACTION PLAN COURSE (WRAP®)

OFFICE USE ONLY RECEIVED: _____
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WRAP® APPLICANTS ONLY: <i>in order to provide you with the best service, please let us know if you require wheelchair access:</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
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**THIS FORM IS TO BE COMPLETED BY THE PROFESSIONAL MOST FAMILIAR WITH THE APPLICAN'T MENTAL HEALTH HISTORY**

**CMHA'S Wellness Programs** promote wellness and community for adults experiencing mental health concerns. Our programs assist individuals to build the skills necessary to support their mental health and aid those experiencing mental illness to develop personal tools to enable meaningful and productive lives.

At the <b>Wellness Development Centre</b> people dealing with mental health issues can improve mental and physical wellbeing by taking part in wellness activities, connecting with others, and contributing to a vibrant community.	<b>Peer Support Services</b> aim to break isolation and provide support from people who understand what it's like to live with mental health issues. One-to-one mentorship is available on a case by case basis.	<b>Kitchen Connections</b> provides an opportunity to volunteer in the kitchen, learn about health and nutrition, and basic employment skills such as teamwork, hospitality, food service, and retail food prep.	The <b>Wellness Recovery Action Plan®</b> or WRAP® is a self-designed prevention and wellness process that anyone can use to get well, stay well, and make their life the way they want it to be. This 6 session course runs on Tuesdays through Thursdays from 9-11am.
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For more information on these programs, go to: <http://cmhakelowna.com/wellness-programs/>

APPLICANT CONTACT INFORMATION						
NAME						
DATE OF BIRTH				GENDER		
	DAY	MONTH	YEAR			
PHONE			CELL #			
EMAIL						
ADDRESS						
CITY				POSTAL CODE		
EMERGENCY CONTACT	NAME		RELATIONSHIP		CONTACT #	

REFERRAL INFORMATION			
REFERRING AGENT NAME			
TITLE/POSITION			AGENCY/ ORGANIZATION
TELEPHONE			FAX
EMAIL			
PSYCHIATRIST			PHONE
MENTAL HEALTH CLINICIAN			PHONE
PHYSICIAN			PHONE

APPLICANT'S MENTAL HEALTH HISTORY			
<b>Mental health diagnosis,</b> Medical conditions And/or Disabilities	Describe:		
Signs of Decompensation: What does it look like when this person becomes unwell?	Describe:		
Has applicant been prescribed psychiatric medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	If medication not used as prescribed, please explain:	
If yes, does the applicant use medication as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
Does applicant have a history of substance misuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Any comments on this?	
If yes, are they currently using?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
Does applicant have a history of violence?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	If yes, please provide details	
Has applicant been informed of this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long have you been working with the applicant?	
REFERRING AGENT SIGNATURE		DATE	

Our programs are group-oriented and for each referral we take into consideration the fit and appropriateness of the applicant. If we feel we are unable to provide an appropriate level of service for your client, you will be contacted by our Wellness Staff. CMHA will make every effort to review referrals within three (3) business days and applicants will be contacted directly to arrange an appointment. We are unable to process incomplete or illegible referrals.