Canadian Mental Health Association
Kelowna
Mental health for all

OFFICE USE ONLY
RECEIVED: ____________

KITCHEN CONNECTIONS REFERRAL FORM

PLEASE FAX COMPLETED FORM TO 250-763-4827

ATTENTION: TRACI COOKE, COORDINATOR

KITCHEN CONNECTIONS: NUTRITIONAL RESOURCES, EDUCATION, TRAINING			
REFERRING AGENT		ORGANIZATION	
PHONE NUMBER		EMAIL	
APPLICANT INFORMATION			
NAME		DATE OF BIRTH	
ADDRESS			
POSTAL CODE		LEVEL OF EDUCATION COMPLETED	
PHONE NUMBER		EMAIL	
PREVIOUS EMPLOYMENT HISTORY			
OTHER PROFESSIONALS INVOLVED			
WHAT WOULD THE APPLICANT BENEFIT FROM THIS PROGRAM?			

KELOWNA BRANCH | 504 Sutherland Ave Kelowna BC V1Y 5X1 | T: 250.861.3644 | F: 250.763.4827| www.kelowna.cmha.bc.ca

WHAT ARE SOME KEY LEARNING AND LIFE GOALS THAT THE APPLICANT WOULD LIKE TO ACCOMPLISH WHILE IN THIS PROGRAM?	
DOES THE APPLICANT HAVE ANY PHYSICAL BARRIERS THAT WOULD LIMIT THEIR ABILITY TO PERFORM IN A KITCHEN SETTING?	❒ YES ❒ NO
IF YES, PLEASE DESCRIBE:	
HAS THE APPLICANT BEEN DIAGNOSED WITH A MENTAL HEALTH DISORDER?	❒ YES ❒ NO
IF YES, PLEASE DESCRIBE:	
DOES THE APPLICANT HAVE ANY DEVELOPMENTAL DISABILITIES?	❒ YES ❒ NO
IF YES, PLEASE DESCRIBE:	
IS THE APPLICANT ACTIVELY INVOLVED WITH OR IS THERE A HISTORY OF SUBSTANCE USE/MISUSE?	❒ YES ❒ NO
IF YES, PLEASE DESCRIBE:	
IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO ADD IN REGARDS TO THIS APPLICANT?	❒ YES ❒ NO

ALL REFERRALS WILL BE REVIEWED WITHIN 7 DAYS OF RECEIPT AND A SUITABILITY/SCREENING INTERVIEW SCHEDULED.

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