Canadian Mental Health Association
Kelowna
Mental health for all

WELLNESS PROGRAMS REFERRAL FORM

☐ WELLNESS DEVELOPMENT CENTRE (WDC)
☐ PEER SUPPORT GROUP ☐ PEER SUPPORT 1 ON 1
PLEASE SELECT ALL THAT APPLY

FAX COMPLETED FORM TO 250-763-4827

OFFICE USE ONLY

RECEIVED:

THIS FORM IS TO BE COMPLETED BY THE PROFESSIONAL MOST FAMILIAR WITH THE APPLICANT'S 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 **Wellness Development Centre (WDC)** those dealing with mental health issues can come to connect with others, engage in wellness-based activities, learn and improve mental and physical wellness and contribute to a vibrant community. WDC programs offer opportunities for fitness, nutrition, recreation, skill-building and socialization, at CMHA and within the greater community.

Peer Support Services are for people coping with the isolating effects of mental health issues and stigma. Peer Support is for anyone who wishes to connect with other individuals with lived experience in a wellness-based environment. We aim to break isolation and provide support from people who understand what it's like to live with mental health issues. One-on-one mentorship is available on a case by case basis.

APPLICANT CONTACT INFORMATION			
NAME			
DATE OF BIRTH (DD/MM/YYYY)		❑ MALE ❑ FEMALE ❑ TRANSGENDER	
TELEPHONE		CELL PHONE	
ADDRESS		EMAIL	
ACCOMMODATION	❑ ALONE/ROOMMATES ❑ FAMILY ❑ RESIDENTIAL FACILITY ❑ OTHER	NAME OF RESIDENTIAL FACILITY:	
EMERGENCY CONTACT		PHONE	

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

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

APPLICANT'S MENTAL HEALTH HISTORY		
MENTAL HEALTH DIAGNOSIS, MEDICAL CONDITIONS AND / OR DISABILITIES	DESCRIBE:	
SIGNS OF DECOMPENSATION	DESCRIBE:	
HAS APPLICANT BEEN PRESCRIBED PSYCHIATRIC MEDICATION?	❑ YES ❑ NO ❑ UNSURE	IF MEDICATION **NOT** USED AS PRESCRIBED, PLEASE EXPLAIN:
IF YES, DOES APPLICANT USE MEDICATION AS PRESCRIBED?	❑ YES ❑ NO ❑ UNSURE	
DOES APPLICANT HAVE A HISTORY OF SUBSTANCE MISUSE?	❑ YES ❑ NO ❑ UNSURE	DESCRIBE SUBSTANCE USE HISTORY WHERE APPLICABLE:
IF YES, ARE THEY CURRENTLY USING?	❑ YES ❑ NO ❑ UNSURE	
DOES APPLICANT HAVE A HISTORY OF VIOLENCE?	❑ YES ❑ NO ❑ UNSURE	IF YES, PLEASE PROVIDE DETAILS:
HAS APPLICANT BEEN INFORMED OF THIS REFERRAL?	❑ YES ❑ NO	HOW LONG HAVE YOU BEEN WORKING WITH THE APPLICANT? _____
PLEASE TELL US WHY YOU FEEL THAT OUR WELLNESS PROGRAMS ARE AN APPROPRIATE RESOURCE FOR YOUR CLIENT:		
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.

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