Canadian Mental Health Association
Kelowna
Mental health for all

WELLNESS PROGRAMS REFERRAL FORM

FAX COMPLETED FORM TO **250-763-4827**

- ***Step 1:*** *Submit this form for access to any or all programs/services below.*
- ***Step 2:*** *CMHA Staff will contact applicant directly.*
- ***Step 3:*** *Attend orientation.*

Date received: _____

FAX COMPLETED FORM TO **250-763-4827**

THIS FORM IS TO BE COMPLETED BY THE PROFESSIONAL MOST FAMILIAR WITH THE APPLICANT.
We can not accept referrals that are incomplete.

CMHA'S Wellness Development Center promotes wellness, skill-building and community for adults experiencing mental health challenges. *Please note this is not clinical, therapeutic or 1-1 support.*

What's we offer at the Wellness Development Centre?

- *ArtWorks Studio* – Join a weekly free art class, or use open studio time to be creative and connect with others.
- *Peer Support Services* – Join one of our Peer Support groups or receive 1-1 Peer Support to break isolation and share with people who understand what it's like to experience a mental health challenge.
- *Coffee and tea bar* – Have a cup of coffee or tea for $0.25, while you connect with others.
- *Skill-building* – This group focuses on a mental health topic, where we learn about and practice a skill.
- *Yoga* – A weekly free class lead by a qualified yoga teacher.
- *Socialisation and activities* – join us for activities like bingo, Jeopardy!, and more, or join for some conversation.
- *Park Days (summer only)* – meet us at one of Kelowna's community parks for outdoor games and socialisation

APPLICANT CONTACT INFORMATION						
NAME						
DATE OF BIRTH	DAY	MONTH	YEAR	GENDER		
PHONE				PRONOUNS (she/her, he/him, they/them)		
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	

Canadian Mental Health Association
Kelowna
Mental health for all

WELLNESS PROGRAMS REFERRAL FORM

FAX COMPLETED FORM TO 250-763-4827

APPLICANT'S HEALTH HISTORY		
Health information: Any mental health diagnosis or challenges, Allergies, Disabilities, or specific accommodations needed	Describe:	
Signs of Decompensation: What does it look like when this person becomes unwell and needs support?	Describe:	
Has applicant been prescribed psychiatric medication?	Yes No Unsure	If medication not used as prescribed, please explain:
If yes, does the applicant use medication as prescribed?	Yes No Unsure	

Is the applicant currently actively using substances?	Yes No Unsure	Any comments on this?
If yes, would this pose a significant challenge to participation in group activities?	Yes No Unsure	
Does applicant have a history of violence or criminal record?	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?

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. Applicants will be contacted directly to arrange an appointment. We are unable to process incomplete or illegible referrals.