Centennial Place #: 604-820-6355 Address: 33032 11th Ave , Mission, BC Website: centennialplacemission.ca

CLUBHOUSE REFERRAL FORM

Date: _____

Name (person requesting service)**:**	**Date of Birth:** dd / mm / yy	**I identify my gender as:** ☐ **Male** ☐ **Female** ☐ **Trans** ☐ **Other** ☐ **Prefer not to disclose**

Home Address:	**Phone Number:**	**E-mail Address (optional):**

Cultural Group[1] you identify with (please refer to definitions provided below) – optional:
☐ White ☐ Black ☐ Aboriginal ☐ Chinese ☐ Japanese ☐ South Asian ☐ Southeast Asian
☐ Korean ☐ Filipino ☐ Latin American ☐ Arab/West Asian

Mental Health (MH) Centre: (+ phone #)	**Case Manager:** (+ phone #)	**GP** (Family Doctor)**:** (+ phone #)	**Psychiatrist:** (+ phone #)

Emergency Contact (Name, Relationship, Phone Number**):**

Type of Accommodation (optional): ☐ Alone ☐ Family ☐ Residential Facility ☐ With others:_____

Family/Social (optional): ☐ Single ☐ married/common-law # of children: _____

Significant family relationships: _____ Specific social supports (e.g. friends, church): _____

Pertinent Medical Information (physical limitations, allergies/seizures, etc):

What mental health issues impact your life?

When should we contact your case manager?

Why would you like to attend the clubhouse program?

- What are some of the things you are interested in?

What could prevent you from attending the clubhouse (e.g., transportation, language difficulties, childcare, etc**)?**

[1] Definition of Cultural Groups:

South Asian – e.g., East Indian, Pakistani, Sri Lankan, etc.	West Asian – e.g., Iranian, Afghani, etc.	Southeast Asian – e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.

Revised April 2014

Highest educational level completed (optional, e.g. for upgrading purpose):	**Source of Income (optional):**

What are some factors or challenges that may have interfered with your wellness? (e.g., suicidal thoughts, alcohol and/or drug use, violent acts towards others or personal property, involvement with the criminal justice system, etc.)

- If you identified any challenge/s above, what kind of support/s are you currently receiving?

I understand that by signing this referral, I am also authorizing the Mental Health Centre and/or Referral Source (physician, agency staff) to exchange relevant information as the need arises. This authorization expires when membership ends.

_____ _____

Signature of Client *Print Name + Signature of Referral Source (Case Manager/GP/Agency)*