**WRAP-Wellness Recovery Action Plan**

**Referral Form – Peer Outreach**

Please submit all referral forms to Alicia Beddoe @ [abeddoe@cmhahkpr.ca](mailto:abeddoe@cmhahkpr.ca)

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| Client Name: |  | |
| (Please check spelling for certificate purposes): | | |
| Name of Referring Person: | |  |
| Referral Submission Date: | |  |
| Clients Phone Number: | |  |
| Clients Email (optional): | |  |

Preferred method of contact:  Email  Phone

Messages okay:  Yes  No  Discrete

Does this person currently have a CMHA Support?  Yes  No

Has the referred person taken the WRAP Workshop before? Yes No

Will this person benefit from attending one to one appointments afterwards to complete the written portion of the WRAP? Yes  No  Unknown

Any concerns to facilitator should be aware of:

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