**WRAP-Wellness Recovery Action Plan**

**Referral Form – Peer Outreach**

Please submit all referral forms to Alicia Beddoe @ 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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