 **Peer Outreach Services Referral Form**

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| Name: |  |
| Pronouns: |  |
| Date of Birth: |  |
| Address: |  |
| Catchment Area: | Peterborough [ ]  Peterborough County [ ] City of Kawartha Lakes [ ] County of Kawartha Lakes [ ]  |
| Phone Number: |  |
| Can we leave a voicemail at this number?  | [ ]  Yes [ ]  No [ ]  Discrete |
| Is the Person aware of this referral? | [ ]  Yes [ ]  No  |
| Name of Referring Person: |  |
| Contact information of referring person: |  |
| Any other Support Workers involved: |  |
| Referral Submission Date: |  |
| Other Contacts and Consents: |  |

1. Please check **one** of the following areas the person may require support and assistance with (feel free to write more detailed information on the back of the form or in the box). See second page of the referral form for an outline of goal outcomes and support provided for each of the areas listed below. *Box can be checked by double clicking on it and selecting “checked.”*

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| **Services Provided by** **Peer Outreach Worker** |
| Assertive Communication | [ ]  |
| Development of Daily Living Routines(ADL’S) | [ ]  |
| Physical Wellness | [ ]  |
| Wellness Tools/Strategies | [ ]  |
| Medication Practices in your Recovery  | [ ]  |
| Emotional Regulation | [ ]  |
| Personal Recovery Goal Setting | [ ]  |

1. Please explain the person’s strengths and needs.

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1. Historically have there been any complications in supporting this person? What efforts have been made to address them?

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1. Please indicate any other risk factors for the person.

Please forward your completed referral form to poref@cmhahkpr.ca and a Peer Outreach Worker will be in contact with you following your application.

**Assessment completed by:**

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|  |

***For Program Manager Only:***

Person is Approved [ ]  Not Approved [ ]

Signature: Date:

Name of Peer Outreach Worker Assigned: