Patient/Client & Family Council

PEER SUPPORT **REFERRAL** FORM

Peer support is a supportive peer relationship with someone who has their own lived experience with mental health and/or addiction challenges. It is a safe and supportive space to talk, feel heard, build hope, and work toward personal goals. Peer support is not counselling or crisis support, but it can be used along with other services.

Name: _____ **Services for:** Individual ☐ Family Member ☐

Pronouns: _____ Date: _____

Address: _____ Town: _____

Phone: _____ Can a Voicemail be left? ☐ **Yes** ☐ **No**

Email: _____

Age Group:

☐ 16-25 ☐ 26-55 ☐ 56+

Preferred Method of Contact:

☐ Call ☐ Text ☐ Email

Referral Information:

☐ Self Referral ☐ Agency Referral

*If Agency referral, please provide the following:

Agency Name & Contact: _____

Telephone Number: _____ Email: _____

The referred person has given permission for this referral to be made: ☐ **Yes** ☐ **No**

Services you would like to access:

☐ Individual (1:1) Peer Support ☐ Groups/Workshops

***For inpatients only:**

Expected discharge date: _____

Preferred Peer Support: _____

☐ I have consented to providing my contact and discharge information to the Patient/Client & Family Council (PCFC) and acknowledge they will contact me upon my return to the community. This information will only be used by PCFC and will not be shared with any other external agencies.

Client Signature: _____

Date Received: _____ Received By: _____

Date of First Contact: _____ ☐ Intake Complete

PCFC