Groups Referral Form - 2026/2027

Developmental Disabilities Mental Health Services Groups
For Adult Persons with Mild Intellectual Disabilities

All groups will be 10:00—11:30 AM , except Grief and Loss which will be 10:30 - 12:00

A support person will need to attend all but the Healthy Relationships group unless no such person exists for client.

Dealing with Feelings of Anxiety or Depression (DWF)

- ☐ **Fall 2026: Surrey (CLBC))**
  #2017 - 7495 132 St, Surrey, BC
  October 6, 13, 20, 27, November 3, 10
- ☐ **Winter 2027: Vancouver (DDA)**
  624 West 8th Street, Vancouver
  January 25, Feb 1, 8, 22, March 1, 8

Skills for Building Emotional Resilience
A Modified DBT group

- ☐ **Fall 2026 - Winter 2027: Mission (MACL))**
  32540 Logan Ave, Mission, B.C.
  October 1, 8, 15, 22, 29, November 5, 19, 26, December 3, 10, January 21, 28, February 4, 11, 18, 25
- ☐ **Winter/Spring 2027: Surrey (DDMHS)**
  9634 King George Blvd Surrey
  Feb. 17, 24, March 3, 10, 17, 24, 31, April 7, 14, 21, 28, May 5, 12, 19, 26, June 2

Keeping Up with Feelings (DWF prerequisite)

- ☐ **Fall 2026: Abbotsford (Bethesda)**
  2775 Emerson St, Abbotsford
  October 5, 19, 26, November 2, 9, 16, 23, 30

Healthy Relationships and Sexual Health

- ☐ **Spring 2027: Mission (MACL)**
  32540 Logan Ave, Mission, B.C.
  April 5, 12, 19, 26,May 3, 10, 17, 31,June 7

Grief and Loss

- ☐ **Winter 2027 - Chilliwack - Location tba**
  January 26, Feb. 2,9, 16, 23, March 2, 9, 16, 23

Keeping It Cool with Angry Feelings

- ☐ **Spring 2027: Ladner (Kyndred)**
  4917 Delta St., Ladner, B.C.
  April 13, 20, 27, May 4, 11, 18

Client name:_____

Please FAX completed referral to 604-461-2189 Or MAIL: 9634 King George Blvd, Surrey British Columbia V3T 0G7 Questions? Email anne.taylor@fraserhealth.ca

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Referral Criteria: Participant must…

- have a mild intellectual disability (IQ 50 - 70)
- be aged 19 years or older
- be under a doctor's supervision if they have psychiatric medications (can be GP)
- be able to participate in group discussions
- be able to attend all sessions unless ill
- have no current suicidal thoughts, except for the modified DBT group, see details following

PLEASE COMPLETE THE FOLLOWING:

Please note:

***All of the following questions must be answered for participant to be considered for a group.*

***No referrals received through email will be accepted.**Please print clearly as faxes can distort writing.*

Participant's Name:_____

Participant's Date of Birth: _____ Personal Health Number:_____

Address: _____

Participant's Email Address: _____

Participant's Cell Phone Number: _____

Participant's Home Phone Number: _____

Name and position of person filling in this referral: _____

Email and phone of person filling in this referral: _____

Name and email (if different from above) of family or support person contact: _____

_____

If participant is served by DDMHS, name of primary clinician: _____

Would participant like to self-identify as an Indigenous or Aboriginal person? ☐ No ☐ Yes

Are there any cultural or spiritual practices that might impact or assist care? ☐ No ☐ Yes

If yes, describe _____

_____

Indicate who, if not client, has signing authority: _____

Client name: _____

PARTICIPANT INFORMATION:

Note*:Each question below must be fully answered for participant to be considered for a group. Write "none" if the answer is none, leaving no blank spaces. Incomplete referrals will not be processed.**

Psychiatric Diagnosis: _____

Group participants must have a mild intellectual disability (IQ 50-70).

Yes, participant is in the mild range and also able to communicate in some way: ❑

No, participant is NOT in the mild range of intellectual disability: ❑

Please write all behavioural issues and reasons participant is being referred:_____

_____

_____

_____

Specify what you are hoping participant will achieve through this group:_____

_____

_____

Do you anticipate that this participant will be safe in a group setting with self and others? Please note anything that might be difficult for them or others: _____

_____

Participants who have had recent suicidal thoughts or attempts (within the previous four + months) will need to be seen by a counsellor or mental health worker who is able to give them more rapid and thorough care than they could receive in our group setting. For that reason participants who are suicidal will be ruled out as not being eligible to attend our groups unless it is our Modified DBT group. If they need more services in this area please call 9-11, go to a hospital, or during a non-emergency call a local mental health team, or call our team number on the front of this form. Please indicate here:

No, participant has NOT had recent suicidal ideation or attempts: ❑

Yes, participant HAS had recent suicidal ideation or attempts: ❑

Client name: _____

CLIENT INFORMATION:

Note*:Each question below must be fully answered for participant to be considered for a group. Write "none" if the answer is none, leaving no blank spaces. Incomplete referrals will not be processed.**

During group we provide a snack break, specifiy food allergies:_____

Support Persons:

Participants will need a support person to attend each group session with them (except the Healthy Relationships group where they may have a choice if they have a support person). A support person can be a family member or a staff support person. The support person will need to sit with client during group, help with communication in the group where needed, and to assist with homework during the week. Please be aware that supporting someone, especially in the grief group, can be emotionally challenging for the supporter as well as the participant, and group facilitators will acknowledge this. If a participant has absolutely no support person who can attend with them please communicate with anne.taylor@fraserhealth.ca to discuss this.

Name of support person who will attend group: _____

Support person's email and phone number:_____

Does a sign-language or other interpreter need to be present to assist participant or caregiver?

No, not required: ❑

Yes, required: ❑ Please detail need: _____

Client name: _____

Information Specific to the Modified DBT group:

NOTE:

Our modified DBT group is specifically meant for individuals who experience intense emotions, emotional ups and downs, self-injury, frequent crises, or difficulties managing relationships. It is suitable for persons with Borderline Personality Disorder or for those who have its traits. This is the only group that may accept participants who are currently experiencing suicidal thoughts, but those participants must have a safety plan and an outside clinician involved in their care.

The following questions are specific to those who are wanting to attend the Modified DBT group:

NO, participant has NOT had recent suicidal ideation or attempts, so no safety plan is attached to this form : ❑

YES, participant HAS had recent suicidal ideation or attempts, wants the modified DBT group and you have attached to this referral their safety plan: ❑

Name, occupation, and role of the counsellor/mental health professional who is managing the safety plan:

_____

Email and phone number of the counsellor/mental health professional who is managing the safety plan:

_____

Check off any behavioural programs and plans that you have attached to this referral:.

❑ Data collection attached

❑ Functional assessment attached

❑ Assessment of Controlling Events attached

❑ Environmental assessment attached

❑ Current behavioural plans attached

❑ Past behavioural plans attached

❑ Other _____