Groups Referral Form - 2022/2023

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

Please check below the group requested.

Healthy Relationships and Sexual Health

Times: 10:00—11:30 AM

- ❑ CLBC #210 - 1200 Lynn Valley Road,North Vancouver Sept. 30, Oct. 7, 14, 21, 28, Nov. 4, 18, 25, Dec. 2, 2023
- ❑ HOME Society, 33140 Mill Lake Road, Abbotsford - Jan. 23, 30, Feb. 6, 13, 27, Mar. 6, 13, 20, 27, 2023
- ❑ Community Living Society, 713 Columbia Street, New Westminster -April 14, 21, 28, May 19, 26, June 2, 9, 16, 23, 2023

Grief and Loss

- ❑ DDA, 624 West 8th, Vancouver - 10:00 - 11:30 AM - Feb. 3, 10, 17, 24, Mar. 3, 10, 17, 24, 2023

Dealing with Feelings of Anxiety or Depression

- ❑ Location: Connective, Unit 101 – 33131 S. Fraser Way, Abbotsford - 10:00-11:30 AM - Oct. 19, 26, Nov 2, 9, 16, 23, 2022
- ❑ Online zoom- 10:00 - 11:00 - Oct 3, 17, 24, 31, Nov 7, 14, 2022
- ❑ Online zoom - 10:00 - 11:00 - Jan. 25, Feb. 1, 8, 15, 22, March 1, 2023
- ❑ RMACL, Maple Ridge, location tbd - 10:00-11:30 AM - April 17, 24, May 1, 15, 29, June 5 2022

Keeping Up with Feelings (DWF Part 2)

- ❑ Online zoom - 10:00 - 11:30 AM April 19, 26, May 3, 17, 24, 31, June 7, 14, 2023

Client name: ______________________________

***Please fax* completed referral to (1) - 604-461-2189**
***Or Mail:* #207 - 2248, Elgin Street Port Coquitlam, B.C., V3C 2B2**

fraserhealth
Better health. Best in health care.

Referral Criteria: Client must…

- have a mild intellectual disability (IQ 50 - 70)
- be aged 19 years or older
- be treated/under doctor's supervision if they have any psychiatric diagnoses
- be able to participate in group discussions
- be able to attend all sessions unless ill

PLEASE COMPLETE THE FOLLOWING:

Please note:

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

***No referrals received through email will be accepted.*

Client Name: ____

Client Date of Birth: ____

Personal Health Number: ____

Address: ____

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Client Email Address (*required for sending zoom link*): ___________________________

Client Cell Phone Number: ____

Client Home Phone Number: ____

Name of person filling in this referral: ____

Referral person's relationship to client: ____

Email of person filling in this referral: ____

Phone number of person filling in this referral: __________________________________

If client is served by DDMHS, name of primary clinician: __________________________

During in-person groups we serve a snack. Does participant have any dietary issues

or food allergies? If yes, please specify: _______________________________________

Client name: ______________________________

CLIENT INFORMATION:

***Note*: ***Each question below must be fully answered for client to be considered for a group. Incomplete referrals will not be processed.**

Psychiatric Diagnosis: ____

IQ (*must be mild—between 50-70):* ____

Why does the client need this group? : ____

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Any behavioural problems (specify)?: ____

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Details about any recent suicidal ideations or attempts: ____

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What are their communication abilities to join in on group discussions (and is a sign-language interpreter required?): ____

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Clients will need the assistance of a caregiver for all groups except the Healthy Relationships group. Caregiver will need to sit with client during group and to assist with homework during the week. Name of caregiver attending/assisting: ____

Caregiver’s email: ____