New View Centre
2050 Mary Hill Road
Port Coquitlam, BC V3C 2Z8

Phone: 604.941.3222
Fax: 604.552.0849
Website: www.newviewsociety.org

CLUBHOUSE REFERRAL FORM

Date: ______________

Name (person requesting service):	**Date of Birth:** dd / mm / yy	**Gender:** ☐ **Male** ☐ **Female** ☐ **Trans** ☐ **Other** ☐ **Prefer not to disclose**
Home Address:	**Phone Number:**	**E-mail Address (optional):**

Cultural Group[1] **you identify with (please refer to definition provided below) – optional:**
☐ White ☐ Black ☐ Aboriginal ☐ Chinese ☐ Japanese ☐ South Asian ☐ Southeast Asian
☐ Korean ☐ Filipino ☐ Latin American ☐ Arab/West Asian

Mental Health (MH) Centre:	**Case Manager:**	**GP** (Family Doctor):	**Psychiatrist:**
( ) ____-_______	( ) ____-_______	( ) ____-_______	( ) ____-_______

Emergency Contact (Name, Relationship, Phone Number)

Type of Accommodation (optional): ☐ Alone ☐ Family ☐ Residential Facility ☐ With others:_________

Family/Social (optional): ☐ Single ☐ Married/common-law # of children: ____________

Significant family relationships: _______________ Specific social supports (e.g. friends, church): _______________

Pertinent Medical Information (physical limitations, allergies/seizures, etc):

What mental health issues impact your life?

When should we contact your case manager?

Why would you like to attend the clubhouse program?

What are some of the things you are interested in?

What could prevent you from attending the clubhouse (e.g., transportation, language difficulties, childcare, etc)**?**

Highest educational level completed (optional, e.g. for upgrading purpose):	**Source of Income (optional):**

What are some factors or challenges that may have interfered with your wellness? (e.g., suicidal thoughts, alcohol and/or drug use, violent acts towards others or personal property, involvement with the criminal justice system, etc.)

If you identified any challenge/s above, what kind of support/s are you currently receiving?

I understand that by signing this referral, I am also authorizing the Mental Health Centre and/or Referral Source (physician, agency staff) to exchange relevant information as the need arises. This authorization expires when membership ends.

_______________________ *Signature of Client*

_______________________ *Print Name + Signature of Referral Source (Case Manager/GP/Agency)*

[1] Definition of Cultural Groups:

South Asian – e.g., East Indian, Pakistani, Sri Lankan, etc.	West Asian – e.g., Iranian, Afghani, etc.	Southeast Asian – e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.