

Referral Form

Recovery in Action (RIA) Group

RIA is a 7-week support group for adults living with schizophrenia and psychosis that are ready to make changes in their recovery by applying cognitive-behavioural therapy (CBT) skills.

Client Information		
Name	Birthdate (mm/dd/yy)	
Address	Telephone Number Can we leave a voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	E-mail Address (if applicable)
Diagnosis	Current Medication(s)	What other treatment(s) is this client receiving?
Are there any of the following risk factors? <input type="checkbox"/> Suicidal <input type="checkbox"/> Self-harm <input type="checkbox"/> History of violence <input type="checkbox"/> Medication non-compliance <input type="checkbox"/> Other, please specify _____		Does the client have insight about their mental health condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Can the client participate in a group setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the client willing to complete weekly take-home activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Referral Information		
Name	Are you a: <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Clinician (OT, Nurse etc.) <input type="checkbox"/> Social Worker <input type="checkbox"/> Other _____	
Agency Name	Agency Address	
Telephone Number	Fax Number	E-mail Address
Has the client given permission for this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you continue to monitor this client while they attend this group? <input type="checkbox"/> Yes <input type="checkbox"/> No	How did you learn about the group?

Please return completed Referral Form by fax or e-mail to:

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