Institute for Advancements in Mental Health

Recovery in Action (RIA) Referral Form

The RIA Program is a 5-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.

Please note that incomplete information may impact the client's acceptance into the RIA Program.

CLIENT INFORMATION		
Name of Client	**Date of Birth**	**Diagnosis**
Address	**Telephone Number** **Can we leave a voicemail?** □ Yes □ No	**Email Address**
Is the client demonstrating any safety concerns or risk factors? □ Frequent Hospitalizations □ History of Violence □ Legal Challenges □ Suicidal □ Self-Harm □ Substance Use □ Other:		**Is the client taking medication?** □ Yes □ No
Reason for Referral		

REFERRAL INFORMATION		
Name of Clinician	**Title Role**	**Referring Organization/Hospital**
Telephone Number with Extension and/or Email	**How did you learn about the RIA Program?**	
Has the client given permission for this referral? □ Yes □ No	**Will you continue to monitor this client while they attend the RIA Program?** □ Yes □ No	

Please return completed Referral Form by <u>fax or e-mail</u> to:

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