Richmond Mental Health
Consumer and Friends' Society (RCFC)
Peers supporting Peers

Peer Support Program
APPLICATION PACKAGE

Address: 210 - 7671 Alderbridge Way, Richmond, BC V6X 1Z9
Phone: 604-675-3977 | **Fax:** 604-214-0947 | **Web:** www.vch.ca/rcfc

PARTICIPANT INFORMATION

First Name		**Last Name**			
Address					
City		**Province**		**Postal Code**	
Phone		**Email**			
Birth date		**Medical Services Plan #**			

EMERGENCY CONTACTS

	NAME (PLEASE PRINT)	**PHONE**
Relative/Partner:		
Family Doctor:		
Psychiatrist:		
Mental Health Worker:		
Other:		

Allergies - List all known allergies, including food, insect bites, vegetation, etc **and their effects**

Physical Health - List any health considerations pertinent to leisure activity and exercise (e.g., diabetes, physical injuries or limitations, seizures, high blood pressure, etc)

Environmental Stressors – Describe any situations or environmental stimuli which may cause undue stress, anxiety or fear, etc (and therefore should be avoided)
Medications – List all medications **and what they are for** (e.g., insulin for diabetes)

ACKNOWLEDGEMENT & CONSENT

By signing below, I acknowledge that to the best of my knowledge the information provided on this form is complete and accurate, and will be kept in secure confidence by the Peer Support Workers and Staff employed by the Richmond Mental Health Consumer and Friends' Society (RCFC).

I further understand and accept that the program is expressly for adults in recovery from a mental illness with no recent history of unsafe behaviour, and that my ongoing **voluntary** participation may be conditional on corroboration of that diagnosis by my doctor or mental health professional.

I further understand and agree that in the event of a psychiatric, medical or other emergency situation, the information will be provided to third parties only as RCFC staff deem necessary for my safety and care.

	NAME (PLEASE PRINT)	**SIGNATURE**	**DATE SIGNED**
Participant:			
Witness:			

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CONSENT FOR RELEASE OF INFORMATION

Richmond Mental Health Consumer and Friends' Society (RCFC) respects and upholds an individual's right to privacy. In order to safeguard client confidences, RCFC acts within the constraints of the law and policies of the "Freedom of Information and Protection of Privacy Act" (https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96165_00).

Please note that in order to determine eligibility, mental readiness and safe behaviour within a group or community setting, it may be necessary to contact the professional and discuss and/or receive information about you. Please indicate your consent to this process below. Your information will be maintained as a confidential, secure record.

For the purposes stated above, **I,** _____ **[PLEASE PRINT YOUR NAME],** give consent to authorized representatives of RCFC to contact:

Name					
Title/Position					
Address					
City		**Province**		**Postal Code**	
Phone		**Fax**			

This consent remains valid for the duration of the individual's participation in the program.

	NAME (PLEASE PRINT)	**SIGNATURE**	**DATE SIGNED**
Participant:			
Witness*:			

***Indicate:** ☐ Physician ☐ Mental Health Professional ☐ RCFC Staff ☐ Other (specify): _____

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REFERRAL FORM FOR RCFC PROGRAMS
(To be completed by Physician or Mental Health Professional)

Name of Client being referred to RCFC	
Name of Physician or Mental Health Professional (in case of an emergency)	**Phone**
History of physical agression	☐ Yes ☐ No ☐ Unknown
If Yes, please describe, with date of last known incident	
Other behaviour(s) that may pose a safety risk	☐ Yes ☐ No ☐ Unknown
If Yes, please describe, with date of last known incident	
Given what you know of about your client, do you feel they are ready at this time to participate with other peers, either at the Mental Health Team or in the community?	☐ Yes ☐ No
If incidents (above) have been minor, do you have any recommendations on how these can best be prevented?	
Your Name (please print)	
Title/Position	
Date	
Signature	