Canadian Mental Health Association
Calgary
Mental health for all

Peer Options

Art of Friendship Referral Form

Referral Date (dd/mm/yyyy): _____

First Name: _____ **Last Name:** _____

Date of Birth (dd/mm/yyyy): _____

Home Address: _____

_____ **Postal Code:** _____

Is this address your mailing address: ❑Yes ❑ No (if no please provide your mailing address):

_____

Contact Phone Number: _____ **(Home)**

_____ **(Cell/Alternate)**

Permission to leave voice message: ❑ Yes ❑ No

Email: _____

You will receive a confirmation phone call once the referral has been processed.

Gender: ❑ Female ❑ Male ❑ Transgender ❑ Unknown ❑ Decline to answer

Income: I live on less than $2,000 per month or $24,000 per year. ❑ Yes ❑ No ❑ Unsure

Education:

❑ No formal education
❑ Grade 1-6
❑ Grade 7-9
❑ some High School or High School Diploma
❑ some Post-secondary
❑ Post-secondary graduate
❑ Unknown education

Cultural Background: _____

Were you born in Canada? ❑ Yes ❑ No **If no, how many years have you been in Canada?**____

Primary Language: _____

Group Experience (past year): _____

_____

Referral Source:

❑ Alberta Health Services

❑ Community Agency

❑ Self

❑ CMHA Program (please specify) _____

❑ Other (please specify)_____

Mental Health and/or Addiction issue: _____

Additional Information (regarding health issues like diabetes, mobility, cognition, ESL, etc.). Please be specific.:

_____

_____

Referral Contact (Doctor, Therapist, Community Support Worker, etc.)

Name: _____

Telephone:_____

Email:_____

Please return completed form to:
Simrat Sandhawalia, Program Coordinator
Canadian Mental Health Association
Calgary Region
Suite 400, 105 12 Avenue SE
Calgary, AB T2G 1A1

Fax:
(403) 270-3066 Attn. Simrat Sandhawalia

Email:
simrat.sandhawalia@cmha.calgary.ab.ca

Intake Inquires:
Phone: (403) 297-1420

Community Transition Program Inquiries:
Debbie Wiebe, Manager
Phone: (403) 297-0081
www.cmha.calgary.ab.ca