Date received:_____

St. Joseph's Healthcare Hamilton

FAMILY CONNECTIONS REGISTRATION FORM

Please fill out the form below (**one per family**). Please note that **only 2 people from each family** are eligible to participate. All information will be kept confidential. **Please submit as soon as possible as places are limited**.

CONTACT INFORMATION

Name of Family Representative (Primary Contact Person): _____

How are you related to your affected relative? "I am their…."

_____Parent _____Sibling _____Spouse/Partner _____Adult Child

_____Other (Please specify: _____)

Name of Second Family Member (if applicable): _____

How is the second family member related to your affected relative? "They are their…"

_____Parent _____Sibling _____Spouse/Partner _____Adult Child

_____Other (Please specify: _____)

Phone Number (*Please only provide numbers that you are okay with us calling*):

_____ (home) _____ (work)

_____ (cell)

When is the best time to call? _____

Can we leave a brief message (i.e., communicate we are calling from St. Joseph's)?

_____Yes _____No

Do you prefer to be contacted by email? _____Yes _____No

If Yes, please provide email address: _____

Mailing Address:

_____

_____

_____

AVAILABILITY

The Family Connections Group normally runs 3 times a year (winter, spring/summer, fall).

If we ran a group on a weekday evening (6:30-8:30 pm), would you be available to regularly attend class over a 12 week period?

_____Yes _____No

I am not available on weekday evenings. Please contact me if alternative times become available in the future. _____ (*please check if appropriate*)

PLEASE TELL US MORE….

How did you hear about the class?

_____

_____

Are you currently living with your affected relative?

_____Yes _____No

Has your relative been formally diagnosed with Borderline Personality Disorder? **Please note this does not impact your eligibility to participate in Family Connections.**

_____Yes _____No _____Unsure

Is your family member currently receiving treatment for Borderline Personality Disorder? **Please note this does not impact your eligibility to participate in Family Connections.**
_____Yes _____No _____Unsure

Briefly describe your situation with your Borderline Personality Disorder loved one:

_____

_____

_____

_____

In the space below, please write your main objective(s) for taking this class. What do you hope to take away from this class? This information will be helpful for your class leaders.

_____

_____

_____

_____

_____

Please submit form to the following address:

Karin Anderson, CPRP
Peer Support Worker
Bridge to Recovery Program
Community Psychiatry Clinic
St. Joseph's Healthcare Hamilton
100 West 5th Street
Hamilton, ON L8N 3K7
905-522-1155 ext. 32081
Fax: 905-308-7217