

CBT Skills Group Program Referral Form

Attn: CBT Skills Group
 tel 778.746.1705 fax 778.265.0298
 email cbtskills@divisionsbc.ca

PATIENT CONTACT INFORMATION			
Last Name		First Name	
Date of Birth (DD/MM/YYYY)		Gender	PHN
D D / M M / Y Y Y Y			
Telephone Number (including applicable area codes)	City	Prov	Postal Code
*EMAIL REQUIRED, OR REFERRAL WILL NOT BE ACCEPTED			
*PATIENT EMAIL			
FAMILY PHYSICIAN			
Last Name		First Name	
MSP #			
Office Telephone Number (including applicable area codes)		Fax Number	
REFERRING CLINICIAN (if different from FAMILY PHYSICIAN)			
Last Name		First Name	
<input type="radio"/> I am a walk-in physician <input type="radio"/> I agree to be the MRP (If agree, please complete the family physician section above)			
Referring Agency			
*REQUIRED, OR REFERRAL WILL NOT BE ACCEPTED			
*PHQ-9 Score <input type="text"/> Score must be <19	Please check PHQ-9 question #9. If positive (score of 1 or greater), please note that acutely suicidal patients are not appropriate. Risk assessment with subsequent safety planning may be necessary. Consider referral to services for patients of higher acuity. Please use judgment about referring such patients after assessing, and be aware that the patient must have a family doctor who agrees to act as MRP.		
PATIENT HISTORY			
Has the patient agreed to the referral? <input type="radio"/> Yes <input type="radio"/> No Is this request a re-referral? <input type="radio"/> Yes <input type="radio"/> No	Please confirm that the patient is appropriate for group-based learning: <input type="radio"/> is not at risk to harm self and/or other <input type="radio"/> is not cognitively impaired <input type="radio"/> substance use (if present) would not interfere with group-based learning <input type="radio"/> does not have a personality disorder that might interfere with group process <input type="radio"/> does not have active psychosis, mania, or dissociation	Has the patient had previous CBT-based treatment? <input type="radio"/> Yes <input type="radio"/> No	
Psychiatric Diagnosis: <input type="radio"/> 300 Anxiety Disorder <input type="radio"/> 311 Depressive Disorder <input type="radio"/> 309 Adjustment Reaction <input type="radio"/> 316 Psychological Factors Affecting Other Medical Conditions <input type="radio"/> 300.4 Dysthymic Disorder	Relevant history and medications: <div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p>Patients cannot be referred without an identified MRP. A primary care provider must be available to provide therapeutic support if necessary. This program cannot provide emergency/additional sessions/supports.</p>		

