Print Form

CBT Program Referral Form
Skills Groups

Download form, fill, and fax. For privacy reasons, form cannot be submitted electronically.

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

PATIENT CONTACT INFORMATION

Last Name	First Name

Apt/Suite #	House/Bldg #	Road/Street	Town/City	Prov	Postal Code

Date of Birth (DD/MM/YYYY)	Gender	PHN	Telephone (incl. area codes)
D D / M M / Y Y Y Y			

PATIENT EMAIL	

MOST RESPONSIBLE PRACTITIONER (FAMILY PHYSICIAN, WALK-IN CLINIC PHYSICIAN, OR NURSE PRACTITIONER)

Last Name	First Name

MSP #

Office Telephone Number (including applicable area codes)	Fax Number

REFERRING CLINICIAN (if different from above)

Last Name	First Name

Referring Agency (if applicable)

PATIENT HISTORY

PHQ–9 Score

Score must be <19

If question #9 on the PHQ-9 is positive (score of 1 or greater), note that acutely suicidal patients are not appropriate. Conduct a risk assessment and consider safety planning, and/or referral to services for patients of higher acuity. If you have assessed and still consider the patient suitable for the group, be aware that the patient must have a primary care provider who agrees to act as MRP.

Psychiatric Diagnosis:

- ❍ 300 Anxiety Disorder
- ❍ 311 Depressive Disorder
- ❍ 309 Adjustment Reaction
- ❍ 316 Psychological Factors Affecting Other Medical Conditions
- ❍ 300.4 Dysthymic Disorder
- ❍ Other (specify ICD9 code): _____

Please confirm that the patient is appropriate for group-based learning:

- ❍ is not at risk to harm self and/or other
- ❍ is not cognitively impaired
- ❍ does not have a substance use disorder of a severity that would interfere with group-based learning
- ❍ does not have a personality disorder that might interfere with group process
- ❍ does not have active psychosis, mania, or dissociation

Additional notes to support referral, if needed:

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.

Patient Health Questionnaire – PHQ-9 (www.depression-primarycare.org)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❒	❒	❒	❒
b. Feeling down, depressed, or hopeless.	❒	❒	❒	❒
c. Trouble falling/staying asleep, sleeping too much.	❒	❒	❒	❒
d. Feeling tired or having little energy.	❒	❒	❒	❒
e. Poor appetite or overeating.	❒	❒	❒	❒
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❒	❒	❒	❒
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❒	❒	❒	❒
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	❒	❒	❒	❒
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❒	❒	❒	❒

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

TOTAL SCORE _____

***PHQ-9* score**	***Severity***
0 - 4	Minimal
5 - 9	Mild
10 - 14	Moderate
15 - 19	Moderately severe
20 - 27	Severe

PHQ-9 is adapted from PRIME MD TODAY