

CBT Skills Group Program Referral Form

Attn:	CBT Skills Group		
tel	250-739-5868	fax	250-739-5870

PATIENT CONTACT INFORMATION											
Last Name						First Name					
Date of Birth (DD/MM/YYYY)						Sex			PHN		
D	D	/	M	M	/	Y	Y	Y	Y		
Telephone Number (including applicable area codes)									Prov		Postal Code
*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											
Referring Agency											
*REQUIRED, OR REFERRAL WILL NOT BE ACCEPTED											
*PHQ-9 Score		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.									
Score must be <19											
PATIENT HISTORY											
Has the patient agreed to the referral? <input type="radio"/> Yes <input type="radio"/> No Is this request a re-referral?		Please confirm 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"/> 296 Bipolar Disorder <input type="radio"/> 300.4 Dysthymic Disorder <input type="radio"/> 303/304 Alcohol or drug dependence <input type="radio"/> Other, please specify: _____						Relevant history and medications: _____ _____ _____ _____ _____ 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.					