



Universal Referral Form

Use this one referral form to access all programs, including:

- CBT Skills Foundations
- Skills for Success: ADHD Strategies for Adults
- Raising Resilient Kids Parenting
- CBT Skills for Insomnia
- Mindfulness, Booster, and other groups are offered to patients once they complete foundational groups



ATTN: Mind Space
fax 1-778-265-0298

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 (xxx-xxx-xxxx)
PATIENT EMAIL			Is this patient an MD (i.e. eligible for a physician-only group)?		

MOST RESPONSIBLE PRACTITIONER (FAMILY PHYSICIAN, WALK-IN CLINIC PHYSICIAN, OR NURSE PRACTITIONER, who agrees to act as MRP for the patient during their engagement) *REQUIRED		
Last Name		First Name
MSP #	Office Telephone Number (xxx-xxx-xxxx)	Fax Number (xxx-xxx-xxxx)

REFERRING CLINICIAN (if not an MD or NP, the MRP above must have agreed for you to be their designate)		
Last Name	First Name	Credentials or MSP#
Referring Agency (e.g., PCN, UPCC, if applicable)		

PATIENT HISTORY	
Programs are resourced for adults with mild-moderate illness severity. The programs are NOT for acutely suicidal patients. MRP is responsible for individualized or crisis care needs.	
<p>Eligibility Criteria:</p> <ul style="list-style-type: none"> • Not severely depressed - PHQ-9 score <19 • Not actively suicidal or otherwise at risk for harm to self • Not at risk of harm to others • Not cognitively impaired, MMSE score >26 • Not using alcohol or drugs at a level that would interfere with group-based learning • Not living with personality disorder symptoms that might interfere with group process • Not living with a psychotic disorder • Not currently or recently manic or hypomanic 	<p>Primary Diagnosis:</p> <ul style="list-style-type: none"> <input type="radio"/> 300 Anxiety Disorder <input type="radio"/> 311 Depressive Disorder <input type="radio"/> 309 Adjustment Reaction <input type="radio"/> 314 ADHD <input type="radio"/> V61.2 Parent-child Relational Prob <input type="radio"/> 780.52 Insomnia Disorder <input type="radio"/> Other (specify ICD9 code): _____
<p>I confirm the patient meets each of these eligibility criteria</p> <p>Screening Required: <input type="radio"/></p> <p>PHQ-9 Score <input type="text"/></p> <p>Score must be <19</p>	

Detailed eligibility criteria is available at mind-space.ca (e.g., for those with bipolar disorders, eating disorders, personality disorders, autism spectrum, acquired brain injury, recent or current hospitalization, and others)

Additional notes to support referral



778-746-1705



hello@mind-space.ca



mind-space.ca