CBT Skills Groups

Evidence-based, MSP-Funded, Physician-Led Programs

This One Referral form is for All CBT Skills Programs: Foundations course, Level 2, Raising Resilient Kids and Pilot Programs

PLEASE SELECT CAREFULLY: As your colleagues, we are asking you to help us help you by ensuring the patients you refer are suitable and prepared for group-based learning. **We do not have an intake office or triage clinicians to screen patients; rather, we depend on you.** The more skilled you become at selecting patients and completing the referral form, the better able we will be to quickly and effectively support patients within your ever-increasing panel. You can find the referral form on our website, as well, the referral forms have been embedded in MOIS, Oscar, Med Access and Wolf.

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
Freud	Sigmund

Apt/Suite #	House/Bldg #	Road/Street	Town/City	Prov	Postal Code
	123	Nuerologist street	Victoria	BC	v9a5k9

Date of Birth (DD/MM/YYYY)	Gender	PHN	Telephone (incl. area codes)
0 6 0 5 1 8 5 6	m	1111 111 111	250-555-5555

PATIENT EMAIL	psychoanalyst@email.com

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

Last Name	First Name
Doe	Jane

MSP #
12345

Office Telephone Number (including applicable area codes)	Fax Number
250-123-4567	250-123-7654

REFERRING CLINICIAN (if different from above)

Last Name	First Name

Referring Agency (if applicable)

PATIENT HISTORY

PHQ-9 Score 9
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 Information

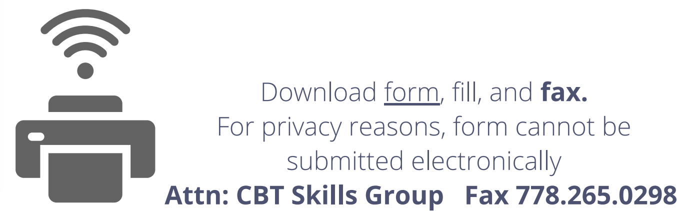
- First/Last Name
- Address
- Postal code
- DOB
- PHN
- Phone number
- Email **this is how we contact the patient*

Most Responsible Practitioner

- 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.
- Complete all fields

Patient History

- PHQ-9 Score <19
- Psychiatric Diagnosis **please review inclusion/exclusion criteria*
- Confirm that the patient is appropriate for group-based learning



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