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**
				BC	
Date of Birth (DD/MM/YYYY)	**Gender**	**PHN**	**Telephone (xxx-xxx-xxxx)**		
PATIENT EMAIL		☐ **The patient being referred is a physician**			

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#
N/A	N/A	N/A

Referring Agency (e.g., PCN, UPCC, if applicable)

Physician Health Program

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.

Eligibility Criteria: Met

- 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

I confirm the patient meets each of these eligibility criteria

☑

Screening Required:

PHQ-9 Score

☐

Score must be <19

Primary Diagnosis:

- ☐ **300 Anxiety Disorder**
- ☐ **311 Depressive Disorder**
- ☐ **309 Adjustment Reaction**
- ☐ **314 ADHD**
- ☐ **V61.2 Parent-child Relational Prob**
- ☐ **780.52 Insomnia Disorder**
- ☐ **Other (specify ICD9 code):** _____

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

Patient Health Questionnaire (PHQ-9)

Provide the total PHQ9 score on the referral. This page does not need to accompany the referral but is provided for your convenience. If the patient has suicidal ideation (question 9), please assess and be mindful that the program is not resourced to support acutely or actively suicidal patients.

Name:_____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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 a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total Score _____

If you checked off any problems, 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