Group Therapy Referral Form

Fax complete referral forms (EMR referral letters are welcome as long as they contain all the information asked for in this form):

(416) 665-2243

***This referral is for a <u>one-time psychiatric assessment to determine suitability</u> for group therapy modality and does not guarantee acceptance into a group therapy program.** The group therapy offered is time-limited, last between 6-12 weeks, after which the patient will be discharged back to their primary care provider.

ALL FIELDS BELOW MUST BE COMPLETED.

Name of Group you're referring to (please see current active group list at www.grouptherapyworks.ca):

_____

Referring Physician: _____ Date (mm/dd/yyyy): _____

Psychiatrist Involved? ☐ Yes ☐ No If Y **please give name/contact:_____**
Other Mental Health Professional Involved? ☐ Yes ☐ No **If Y please give name/contact:_____**
Primary Care Provider name/contact (if different from referring physician): _____

Patient Information: Full Name: _____ D.O.B. (mm/dd/yyyy) _____

Home Address: _____

OHIP #: _____ Version code: ____ Main Phone No.:_____

Alt. Phone No.: _____ Email: _____
consent to leave vm on these phone numbers: ☐ Yes ☐ No **consent to email for admin purposes: ☐ Yes ☐ No**

Emergency Contact Name: _____ Relationship:_____ Phone:_____

Reason for Referral (goals of therapy, target symptoms):

All Psychiatric Diagnosis(es):

PHQ-9 Score:

Brief Psychiatric History (please include any prior Group Psychotherapy experience):

Medical History:

Current Treatment (medications, psychotherapy):

Past psychiatric hospitalizations/emergency visits: (please write the most recent and/or most severe ones, indicate location, reason for admission, approximate dates and length of stay):

Prior psychiatric/assessment notes are attached ☐ No prior psychiatric assessments ☐

Please complete the screening checklists below: Group therapy offered is not appropriate for patient with severe or unstable mental health conditions or requiring immediate crisis intervention for any mental health reason. DBT or trauma therapy are not offered.

Inclusion Criteria:

Motivation to attend group	☐ Yes ☐ No
Availability for 8-12 successive sessions	☐ Yes ☐ No
Ability to tolerate distress and regulate emotions	☐ Yes ☐ No
Ability to complete homework	☐ Yes ☐ No
Has internet / technology access for virtual care	☐ Yes ☐ No

Exclusion Criteria: Please elaborate on any 'Yes' answers to Exclusion Criteria by providing any comments/concerns.

Previous difficulty in group setting	☐ Yes ☐ No _____
Current or recent Alcohol/Drug misuse/abuse/dependence	☐ Yes ☐ No _____
Dissociation or severe emotional dysregulation	☐ Yes ☐ No _____
Aggression/Impulsive behaviour/Homicidality	☐ Yes ☐ No _____
Self-harm/Suicidality	☐ Yes ☐ No _____
Cognitive Impairment	☐ Yes ☐ No _____
Active or recent Psychosis/Mania/Hypomania	☐ Yes ☐ No _____
Psychiatric Admission within last 9 months	☐ Yes ☐ No _____

Personality disorder/traits (including borderline) that would impair group functioning ☐ Yes ☐ No _____

Severe depression/anxiety that prevents engagement in group setting ☐ Yes ☐ No _____

Prominent trauma history or PTSD w/o prior treatment	☐ Yes ☐ No _____
Currently living in Domestic Violence	☐ Yes ☐ No _____

Comments/concerns:

I understand that individual psychotherapy and individual psychiatric care/medication management will not be provided in this clinic. I will plan patient care accordingly. I understand Group therapists will NOT provide assessments or documentation for legal, custody, disability, insurance or WSIB issues. ☐ Yes ☐ No

Physician Signature: _____ Date: _____OHIP Billing Number: _____

Address: _____ Phone: _____ Fax:_____

Upon receiving this referral, you will be notified if the referral has been accepted. The patient will be put on a waitlist and contacted directly when an appointment becomes available for consultation. The wait time may be 4-12 weeks. Thank you kindly for your referral.