Charis Clinic for Mental Wellness

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GROUP THERAPY REFERRAL

Referring Physician

Date of Referral (mm/dd/yyyy) _____ Specialty: _____

MD Name: _____ MD Billing #: _____

Address: _____ Postal code: _____

Phone no: _____ Fax no: _____

Patient Information

First Name: _____ Last Name: _____

Gender: _____ Pronouns: ☐ she, her ☐ he/him ☐they/them ☐ other

D.O.B.: month _____ day _____ year _____ Age: _____

OHIP # (including version code): _____ Marital Status: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home #: _____ Cell #: _____ Email: _____

Consent to leave voice message on the phone number(s) provided: ☐ **Yes** ☐ **No**

Consent to email for administrative purposes: ☐ **Yes** ☐ **No**

Reason for Referral *(i.e. target symptoms, goals of therapy):*

_____

Psychiatric/Comorbid Diagnoses (e.g. depression/anxiety disorders, bipolar disorder, BPD, disorder, PTSD etc.)

_____

Past Psychiatric Hospitalizations/Emergency Visits *(i.e. most recent and/or severe visits, location, reason for admission and approximate dates and length of stay):*

_____

***Please attach any relevant reports e.g. psychiatric hospitalization records, psychological/psychiatric assessments etc. ***

Past Medical History: _____

Current medications: _____

Please confirm:

a) Does the patient have **substance abuse issues?** (if active, please address prior to referral) ☐ Yes ☐ No

b) Has the patient had **suicide attempts**? ☐ No if Yes: ☐ Current ☐Past (when) _____

c) Has the patient exhibited **violent behaviours**? ☐ No if Yes: ☐ Current ☐Past (when) _____

Please complete the eligibility/exclusion criteria screening checklists on the next page.

Eligibility Criteria:

Inclusion Criteria:

- ☐ Ability to communicate in English
- ☐ Motivation & availability to attend group for 8-16 successive sessions
- ☐ Ability to tolerate some distress and regulate emotions
- ☐ Has internet/technology access for virtual video care

Exclusion Criteria:

Please indicate if any exclusion criteria are present and include any additional details if any exclusion criteria apply:

- ☐ Previous difficulty in group/group therapy settings
- ☐ Current or recent substance misuse/abuse/dependence (e.g. alcohol, cannabis, illicit drugs)
- ☐ Dissociation or severe emotional dysregulation
- ☐ Aggression/impulsive behaviours/homicidality
- ☐ Self-harm/suicidality
- ☐ Cognitive impairment (that will likely affect comprehension of therapy material)
- ☐ Active or recent psychosis/mania/hypomania
- ☐ Psychiatric admission within the last 9 months
- ☐ Personality disorder/traits (including borderline) that would impair group functioning
- ☐ Severe depression/anxiety that prevents engagement in group therapy setting
- ☐ Prominent trauma history or PTSD w/o prior treatment (with symptoms that would prevent safe engagement in group)
- ☐ Currently living in crisis/instability/domestic violence

Patients referred must be connected to a Healthcare Provider in the community (please identify below) who is able to provide the patient individual care & follow-up as necessary (e.g. Family Physician, Nurse Practitioner, Psychiatrist, MD Psychotherapist etc.). I will be providing group psychotherapy and will not be taking over patients' overall mental health care during that time. Patients are discharged after the course of group therapy is complete.

Community Healthcare Provider: ☐ Referring Provider ☐ Not Referring Provider (complete below)

Name: _____ *Phone:* _____

*Address:*_____ *Fax:* _____

Referring Provider Declaration:

I understand that this referral is for a one-time intake consultation to determine suitability for group therapy and does not guarantee acceptance into a group therapy program. If accepted, the group therapy offered is time-limited, lasts between 8-16 weeks (depending on the group), after which the patient is discharged back to their primary care provider. I understand that diagnostic clarification, individual psychotherapy/follow-up, mental health care and/or medication management will not be provided by Dr. Yang during this time, and I will plan patient care accordingly. I understand that Dr. Yang and/or other group therapists/co-facilitators will NOT provide assessments or documentation for legal, custody, disability, insurance or WSIB issues. I understand that Dr. Yang cannot assume any medical or legal responsibility for this patient's healthcare while they are awaiting consultation. If my patient is actively planning suicide or presents with immediate risk to self or others, I will refer the patient to the Emergency Department.

Physician Signature: _____ **Date:** _____

Thank you kindly for your referral. 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. Please note, referrals may be declined if the waitlist is expected to be longer than 6 months, if significant exclusion criteria are present, and/or if the patient's presenting concern appears outside the scope of what group therapy can address.