The Art of Living Mindfully (North)

Referral Form

Fx: 250-984-7755
info@bcalm.ca
BCALM.ca

PLEASE COMPLETE **ALL INFORMATION BOXES** BELOW **INCLUDING EMAIL ADDRESS**.
INCOMPLETE OR ILLEGIBLE REFERRALS WILL BE RETURNED.

Date of Referral:		
Client Name:		Phone:
Address:		*****Client Email Address:*** ********
DOB:	Age: 21+ y/o	PHN:
Referred by: Clinic: Phone: Fax:		Family Physician: Phone: Fax:

What are the major stressors this patient is currently experiencing?

Please provide relevant history:

Diagnosis and ICD9 code:

CONDITIONS: Please indicate all that apply:

☐ Depression ☐ Anxiety ☐ Insomnia ☐ Addiction
☐ PTSD ☐ Personality Disorder ☐ Chronic Pain ☐ Acute Stress Situation

List other conditions:

MEDICATIONS: Please indicate all that apply:

☐ Antidepressants ☐ Mood stabilizers ☐ Anti-psychotics
☐ Anti-anxiety ☐ Opioids ☐ Hypnotics/Sedatives ☐NO MEDS

List other medications:

Please confirm this patient is appropriate for group based learning:

☐ substance use **would not** interfere with ability to learn/participate
☐ **is not** at risk to harm self or others
☐ **does not** have a disorder that might interfere with group process
☐ **is not** cognitively impaired
☐ **does not** have **active** psychosis, PTSD, mania or dissociation
☐ **does not** have criminal or legal issues pending

We request that the referring clinician be available to the client for therapeutic support if the need arises.
This program cannot provide emergency/additional sessions or support.

Updated Oct 2018