# The Art of Living Mindfully

Mindfulness Meditation Referral Form

**Fx: (1)250-984-7755**
info@bcalm.ca
BCALM.ca

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

| | | |
|---|---|---|
| Date of Referral: | | |
| Client Name: | | Phone: |
| Address: | | ***Client email address**** |
| DOB: | Age:<br>20+ y/o | PHN: |
| Referred by:<br>Clinic:<br>Phone:<br>Fax: | | Family Physician:<br>Phone:<br>Fax: |

**Please provide brief history and current stressors** ☐ HISTORY ATTACHED

**Diagnosis and ICD9 code:**

**Please confirm whether your patient has received at least 2 doses of a Health Canada approved COVID-19 vaccine** ☐ **yes** ☐ **no**

**CONDITIONS:** Please indicate all that apply:

☐ Depression ☐ Anxiety ☐ Insomnia ☐ Addiction

☐ PTSD **NO ACTIVE SYMPTOMS** ☐ Personality Disorder ☐ Chronic Pain ☐ Acute Stress Situation

Other Conditions:

**MEDICATIONS:** ☐ **NO MEDICATIONS** ☐ LIST ATTACHED

***Please confirm this patient is appropriate for group based learning:*** (In the event of unclear group suitability additional information may be requested)

☐ **DOES NOT** have a**ctive** substance use <6 months ☐ **DOES NOT** have a disorder that might interfere with group learning (eg PD)

☐ **IS NOT** cognitively impaired ☐ **HAS NOT** had **active** PTSD sx for > 6 months (nightmares, flashbacks, dissociation)

☐ **DOES NOT** have criminal/legal issues pending ☐ **DOES NOT** have **active** psychosis ☐ **IS NOT** at-risk to harm self or others

☐ **PATIENT IS AWARE OF AND APPROVES THIS REFERRAL**

☐ **UNDERSTANDS THIS 8 WEEK COMMITMENT; 90-120 MIN CLASS AND 10-30 MIN HOME PRACTICE/DAY**

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.