

Referral Form

Service Description

The **Increasing Access to Structured Psychotherapy - North Simcoe Muskoka (IASP NSM)** program provides access to free in-person structured psychotherapy using individual and group Cognitive Behavioural Therapy (CBT) for adults with **anxiety and/or depression**.

A referral from a primary care provider (family doctor or nurse practitioner) is preferred to access the service.
Please fax this referral form to the IASP Intake Team based at Waypoint: (705) 549-7330.

Consider a referral to BounceBack if your client's scores are within the very mild range (i.e. a score of less than 8 on GAD-7 and less than 10 on PHQ-9): bouncebackontario.ca.

Eligibility Criteria	Yes	No
Client has a primary diagnosis of anxiety and/or depression (based on GAD-7 and PHQ-9 scores completed on page 3)	<input type="checkbox"/>	<input type="checkbox"/>
Client resides in Ontario	<input type="checkbox"/>	<input type="checkbox"/>
Client is aged 18+	<input type="checkbox"/>	<input type="checkbox"/>
A client is not suitable for this program if:	Yes	No
Client is actively suicidal and with impaired coping skills and/or has attempted suicide in the past 6 months	<input type="checkbox"/>	<input type="checkbox"/>
Client poses a high risk to themselves, risk to others, or are at significant risk of self-neglect	<input type="checkbox"/>	<input type="checkbox"/>
Client is self-harming, which is the primary concern	<input type="checkbox"/>	<input type="checkbox"/>
Client has symptoms of acute mania at present or in the past 2 years and/or has a diagnosis of bi-polar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Client has a diagnosis of schizophrenia or schizoaffective disorder and/or significant symptoms of psychosis at present or in the past 6 months	<input type="checkbox"/>	<input type="checkbox"/>
Client has a diagnosis of severe/complex personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
Client has requested only medication management	<input type="checkbox"/>	<input type="checkbox"/>
Client has moderate to severe impairment of cognitive function (e.g. dementia or acquired brain injury); or moderate/severe impairment due to a developmental disability or learning disability	<input type="checkbox"/>	<input type="checkbox"/>
Client's problematic substance use would impact their ability to actively participate in CBT	<input type="checkbox"/>	<input type="checkbox"/>
Client has a severe eating disorder which could impact their ability to actively participate in CBT	<input type="checkbox"/>	<input type="checkbox"/>

Client Information

Name (last, first name): _____ Date of Birth (YYYY/MM/DD): _____
 Preferred Name: _____ Preferred Pronoun: _____
 Address: _____
 City: _____ Postal Code: _____
 Preferred Contact #: _____ Can a message be left at this number? Yes No

Alternate Contact #: _____ Can a message be left at this number? Yes No
Health Card #: _____ Version Code: _____
Main spoken language? English French Other: _____
Has the client been connected with any community services (past or present)?
Please list: _____

Referral Source

Provider's Name (last, first name): _____ Telephone #: _____
Type: Family Physician Nurse Practitioner Psychiatrist Other (e.g. RP/RSW): _____
Billing number: _____ Organization Name (e.g. FHT or CHC): _____
Date of Referral (YYYY/MM/DD): _____ Fax: _____

Primary Care Provider (if different than Referral Source)

Provider's Name (last, first name): _____ Telephone #: _____
Fax: _____ Organization Name (e.g. FHT or CHC): _____

Consent

Is the client aware of and in agreement with this request for service? Yes No

Has the client been provided the Data and Privacy FAQ? Yes No

Your submission of this Referral Form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information contained to Waypoint Centre for Mental Health Care and the IASP service providers. If applicable, please include your Organization's Consent to Release of Personal Health Information Form.

Information Regarding Client's Situation

Please provide any relevant information regarding your client's situation (e.g. events, stressors, substance use): _____

Symptomatology/Medical Status (including medications): _____

Length of time the client has experienced the problem: 0 to 3 months 4 to 12 months Over 12 months

Diagnosis (based on DSM-5 criteria): _____

(Note: Diagnosis to be provided if within scope of practice of referring party)

Patient Health Questionnaire (PHQ-9)

During the **last 2 weeks**, how often have you been bothered by any of the following problems?

Problem	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 TV	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 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 problem on this questionnaire so far, 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

Generalized Anxiety Disorder Assessment (GAD-7)

During the **last 2 weeks**, how often have you been bothered by any of the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: _____