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 mild to moderate 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: (705) 549-7330.

Inclusion Criteria	Yes	No
Client has a primary diagnosis of mild to moderate anxiety and/or depression (based on GAD-7 and PHQ-9 scores completed on page 3)	☐	☐
Client resides in the North Simcoe Muskoka region	☐	☐
Client is aged 18+	☐	☐
Exclusion Criteria	**Yes**	**No**
Client is actively suicidal and with impaired coping skills and/or has attempted suicide in the past 6 months	☐	☐
Client poses a high risk to themselves, risk to others, or are at significant risk of self-neglect	☐	☐
Client is self-harming, which is the primary concern	☐	☐
Client has symptoms of acute mania	☐	☐
Client has symptoms of acute psychosis	☐	☐
Client has a diagnosis of severe/complex personality disorder	☐	☐
Client has requested only medication management	☐	☐
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	☐	☐
Client's problematic substance use would impact their ability to actively participate in CBT	☐	☐
Client has a severe eating disorder which could impact their ability to actively participate in CBT	☐	☐

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 (Eg. RP/RSW etc):_____

Billing number (if referred by physician): _____

Organization Name (if applicable Eg. FHT or CHC):_____

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

Consent

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

Does the client consent to sharing this referral with any of the IASP NSM service providers? ☐Yes ☐No

Information Regarding Client's Situation

Please provide any relevant information regarding your client's situation (i.e. 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: _____