GARUDA CENTRE
THE POWER OF GROUPS ®

PATIENT REFERRAL
FAX TO: +1 250 754 5245

CLEAR FORM | PRINT FORM

GROUP SELECTION

PLEASE CHOOSE WHICH GROUP THE PATIENT IS INTERESTED IN?

TYPE OF ATTENDANCE

IF OTHER,
PLEASE SPECIFY

PATIENT INFORMATION

NAME | DATE OF BIRTH *DD/MM/YYYY* | PHN

***EMAIL** | 10-DIGIT PHONE # | GENDER

FULL MAILING ADDRESS
+ POSTAL CODE

MOST RESPONSIBLE FAMILY PHYSICIAN, WALK-IN CLINIC PHYSICIAN, OR NURSE PRACTITIONER

NAME + TITLE

MSP # | OFFICE PHONE # | FAX #

REFERRING CLINICIAN (IF DIFFERENT FROM ABOVE)

NAME + TITLE

REFERRING AGENCY (IF APPLICABLE)

PATIENT HISTORY

PSYCHIATRIC DIAGNOSIS:

- ☐ 300 - ANXIETY DISORDER
- ☐ 300.4 - DYSTHYMIC DISORDER
- ☐ 308 - ACUTE STRESS DIS./PTSD
- ☐ 309 - ADJUSTMENT REACTION
- ☐ 311 - DEPRESSIVE DISORDER
- ☐ 315 - ATTENTION DEFICIT DISORDER
- ☐ 316 - PSYCHOLOGICAL FACTORS AFFECTING OTHER MEDICAL CONDITIONS
- ☐ OTHER

PLEASE CONFIRM THE PATIENT IS APPROPRIATE FOR GROUP-BASED LEARNING:

- ☐ IS NOT AT RISK TO HARM SELF OR OTHERS
- ☐ IS NOT COGNITIVELY IMPAIRED
- ☐ DOES NOT HAVE A SUBSTANCE USE DISORDER OF A SEVERITY THAT WOULD INTERFERE WITH GROUP-BASED LEARNING
- ☐ DOES NOT HAVE A PERSONALITY DISORDER THAT MIGHT INTERFERE WITH GROUP PROCESS
- ☐ DOES NOT HAVE ACTIVE PSYCHOSIS, MANIA, OR DISSOCIATION
- ☐ IS OPEN TO DOING MINDFULNESS + BREATHWORK
- ☐ IS ABLE TO PARTICIPATE IN 2HR SESSIONS

REASON FOR REFERRAL + ADDITIONAL NOTES TO SUPPORT THE REFERRAL, IF NEEDED:

PATIENTS CANNOT BE REFERRED WITHOUT AN IDENTIFIED MRP. A PRIMARY CARE PROVIDER MUST BE AVAILABLE TO PROVIDE THERAPEUTIC SUPPORT IF NECESSARY. THESE PROGRAMS CANNOT PROVIDE EMERGENCY/ADDITIONAL SESSIONS/SUPPORT.