

CBT-VMS

COGNITIVE BEHAVIOURAL THERAPY (CBT)
FOR VASOMOTOR SYMPTOMS (VMS)

Referral Form

CBTVMS.CA

Fax referral to:
1-250-412-6457

Date of referral: _____

PATIENT INFO

First name		Last name	
Patient date of birth (Month, Day, Year)		PHN	
Patient telephone #		Gender	
Patient email address	Referrals without email will be returned – all group info sent via email.		

REFERRING PHYSICIAN OR NP

First name		Last name	
MSP #		Office fax #	
Clinic name		Office phone #	

MOST RESPONSIBLE PROVIDER (MRP)

This physician (family physician or specialist) or NP agrees to act as most responsible provider (MRP) for the patient while they are engaged in this group treatment.

Tick if same as referring physician above, otherwise complete info below.

MRP first name		MRP last name	
Clinic name		Office phone #	

PATIENT ELIGIBILITY

This group treatment is not designed for patients with severe/unstable mental health conditions, or for those patients requiring immediate crisis intervention for psychiatric or medical concerns. The referring MRP agrees to remain responsible for any individualized or crisis care needs.

INCLUSION CRITERIA

Motivated to attend group training format	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Consents to receive registration info via email, including online booking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Access to technology and a private space for virtual group sessions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Able to complete weekly homework practice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Between the ages of 19 and 65 inclusive	<input type="checkbox"/> Yes	<input type="checkbox"/> No

EXCLUSION CRITERIA

Active substance use which may impact ability to participate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personality disorder/traits which may impact ability to participate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Severe depression/anxiety which may impact ability to participate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cognitive impairment which may impact ability to participate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current or recent (within last 12 months) active suicidality	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of psychosis or mania	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ICD-9 DIAGNOSIS (check all that apply)

<input type="checkbox"/> 627.2 Symptomatic natural menopause	<input type="checkbox"/> 300 Anxiety
<input type="checkbox"/> 627.4 Symptomatic artificial menopause	<input type="checkbox"/> 311 Depressive Disorder
<input type="checkbox"/> 256.31 Symptomatic premature menopause	<input type="checkbox"/> 308 Adjustment Reaction
<input type="checkbox"/> V10.3 Hx of malignant neoplasm of breast	<input type="checkbox"/> 327 Insomnia

Additional diagnoses (if applicable):

ADDITIONAL NOTES FOR REFERRAL (if applicable)
