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 #	

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	☐ Yes	☐ No
Consents to receive registration info via email, including online booking	☐ Yes	☐ No
Access to technology and a private space for virtual group sessions	☐ Yes	☐ No
Able to complete weekly homework practice	☐ Yes	☐ No
Between the ages of 19 and 65 inclusive	☐ Yes	☐ No
EXCLUSION CRITERIA		
Active substance use which may impact ability to participate	☐ Yes	☐ No
Personality disorder/traits which may impact ability to participate	☐ Yes	☐ No
Severe depression/anxiety which may impact ability to participate	☐ Yes	☐ No
Cognitive impairment which may impact ability to participate	☐ Yes	☐ No
Active or recent suicidality	☐ Yes	☐ No
History of psychosis or mania	☐ Yes	☐ No

ICD-9 DIAGNOSIS (check all that apply)

☐ 627.2	Symptomatic natural menopause	☐ 300	Anxiety
☐ 627.4	Symptomatic artificial menopause	☐ 311	Depressive Disorder
☐ 256.31	Symptomatic premature menopause	☐ 308	Adjustment Reaction
☐ V10.3	Hx of malignant neoplasm of breast	☐ 327	Insomnia

☐ ____ Other (with ICD-9 code): _____

☐ ____ Other (with ICD-9 code): _____

☐ ____ Other (with ICD-9 code): _____

ADDITIONAL NOTES FOR REFERRAL