IASP01

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

REFERRAL FORM

Increasing Access to Structured Psychotherapy Champlain

ROYAL OTTAWA HEALTH CARE GROUP
1145 Carling Ave, Ottawa, ON K1Z 7K4
1-877-527-8207 / Fax: 613-715-5821

SERVICE DESCRIPTION

Adults can now access publically funded Cognitive Behavioural Therapy (CBT) as part of Ontario's Increasing Access to Structured Psychotherapy (IASP) program, led in the Champlain region by The Royal. CBT is a goal-oriented, time-limited therapy that helps clients by teaching practical skills and strategies to manage their mental health and improve quality of life. Clients will work individually with IASP therapists for approximately 12 sessions either in person or via telemedicine at The Royal or within IASP community partner agencies located throughout the Champlain region.

BounceBack® may be considered prior to IASP, has your client / patient been referred to BounceBack®? ☐Yes ☐No

ELIGIBILITY CRITERIA	YES	NO
Primary diagnosis of: Depression - Anxiety Disorder(s), including: generalized anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, specific phobia, and health anxiety - Obsessive-Compulsive Disorder - Post-Traumatic Stress Disorder	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Resident of Ontario	☐	☐
Adult (18+)	☐	☐
NOT SUITABLE IF:	**YES**	**NO**
Actively suicidal and with impaired coping skills and/or has attempted suicide in the past 6 months	☐	☐
At high risk to harm self or others or at significant risk of self-neglect	☐	☐
Experiencing significant symptoms of mania or hypomania currently or has experienced these symptoms within the past year	☐	☐
Experiencing significant symptoms of a psychotic disorder currently or has experienced these symptoms within the past year	☐	☐
Has a severe/complex personality disorder that would impact their ability to actively participate in CBT for anxiety or depression	☐	☐
Has a moderate to severe impairment of cognitive function (e.g. dementia); or moderate / severe impairment due to a developmental disability or learning disability which would impact their ability to participate in CBT	☐	☐
Has problematic substance use or has had problematic substance use in the past three months that would impact their ability to actively participate in CBT. Requires specialized concurrent disorders treatment.	☐	☐
Has a severe eating disorder that would impact their ability to actively participate in CBT for anxiety or depression	☐	☐

CLIENT / PATIENT INFORMATION

Name (last, first name):_____ Preferred Name:_____

Date of Birth (yyyy/mm/dd):_____ Health Card #:_____

Address:_____

City:_____ Postal Code:_____ Email:_____

Preferred Contact #:_____ Can a confidential message be left at this number? ☐Yes ☐No

Alternate Contact #:_____ Can a confidential message be left at this number? ☐Yes ☐No

Main spoken language? ☐English ☐French Other: _____ Interpreter required? ☐Yes ☐No

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CLIENT / PATIENT INFORMATION (cont'd)

Francophone? ☐Yes ☐No French language services required? ☐Yes ☐No

Gender: ☐Male ☐Female ☐Trans – Female to Male ☐Trans – Male to Female ☐Intersex ☐Two-Spirit
☐Other ☐Prefer not to answer ☐Do not know

REFERRAL SOURCE

Referrer Name (last, first name):_____ Date of Referral (yyyy/mm/dd):_____

Type: ☐Family Physician ☐Nurse Practitioner ☐Psychiatrist ☐Psychologist ☐Other Clinician

Billing number (if applicable):_____

Address:_____

Telephone:_____Fax:_____

CONSENT

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

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

INFORMATION REGARDING CLIENT'S / PATIENT'S SITUATION

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

_____

_____

_____

Current Medical Problems:

_____

_____

_____

Current Medications:

_____

_____

_____

PHQ-9 score: _____ GAD-7 score: _____

PHQ-9

During the **last 2 weeks**, how often have you been bothered by 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

GAD-7

During the **last 2 weeks**, how often have you been bothered by 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: ☐