Covenant Health

PSYCHOLOGICAL SERVICES REFERRAL FORM FOR THE CBT+ GROUP

patient demographic label

patient barcode label

FAX to
Jayne Taylor
780-735-7496

Please note that outside the Grey Nuns Community Hospital, only physician referrals are accepted

Has the patient been advised of referral? Referral Date:_____

Yes □ No □

Patient Phone Number: _____

1. REASON FOR THE REFERRAL (E.G., DEPRESSION, ANXIETY, EMOTION REGULATION DIFFICULTIES, ETC): Describe the nature of the problem(s) for which psychological treatment is requested.

_____
_____
_____
_____

2. ADDITIONAL INFORMATION OF RELEVANCE (E.G., HISTORY OF PROBLEM, RELEVANT BACKGROUND)

_____
_____
_____
_____
_____

3. CURRENT OR PREVIOUS PSYCHIATRIC DIAGNOSES (IF KNOWN):

_____
_____
_____

4. HISTORY OF SUICIDE ATTEMPTS, NON-SUICIDAL SELF-INJURY, SUBSTANCE ABUSE (IF KNOWN):

_____
_____
_____

Physician Contact Information (Address and Phone number):

_____
_____
_____

Name of Referring Physician (Please Print):_____

Physician's Signature: _____