mind mood
Clinical Care Network

fax: 1-833-333-1809
www.mindandmoodbc.ca

REFERRAL FORM Food As Medicine

Thank you for your referral to our Food As Medicine program for individuals with diagmosed medical conditions. This 8-week program includes weekly 90-minute virtual group medical visits. Please see page 2 for eligibility criteria. All patients must watch the introductory video and complete the included questionnaire prior to referral.

INCOMPLETE REFERRALS WILL NOT BE ACCEPTED AND WILL BE RETURNED

Referring physician information

Name: _____ MSP number: _____

Office address: _____

Office phone: _____ Office fax: _____

Patient information

First name: _____ Last name: _____

MSP number: _____ Date of birth: _____

Assigned sex at birth: _____ Gender: _____ Pronouns: _____

Phone: _____ Email: _____

Address: _____

Medical information

Psychiatric diagnosis: _____

Medical diagnosis: _____

Is your patient located in the Smithers, Bulkley Valley, Terrace or Prince Rupert region? Yes ❑ No ❑

Has your patient had a psychiatric consultation? Yes ❑ No ❑ If yes, please send a copy of the consultation.

Has your patient had a consultation for a pain disorder? Yes ❑ No ❑ If yes, please send a copy of the consultation.

Has your patient had lab tests in the last 6 months? Yes ❑ No ❑ If yes, please send a copy of the lab results.

Eligibility criteria

Before sending the referral, please confirm the following by checking each box:

- ❑ Patient (or family member) is able to cook/prepare their own meals
- ❑ Patient has a diagnosed medical condition including but not limited to anxiety disorders, mood disorders, chronic pain, chronic fatigue, diabetes, hypertension or obesity
- ❑ Patient is not currently manic or hypomanic
- ❑ Patient has not had a suicide attempt in the last 6 months
- ❑ Patient has not had recent recurrent self-harm requiring medical intervention; unwillingness to commit to lowering suicidal/self-harm behaviours
- ❑ Patient does not have an active substance use disorder interfering with their ability to engage in therapy
- ❑ Patients does not have an active eating disorder interfering with their ability to engage in therapy
- ❑ Patient does not have active psychosis
- ❑ Patient does not have moderate to severe autism spectrum disorders, intellectual disability, or cognitive impairment interfering with their ability to engage in therapy
- ❑ Patient does not have any other untreated major psychiatric disorders (e.g. severe panic disorder, OCD) requiring more specific evidence-based treatments for these conditions

Please have your patient complete the following steps:

1. **Watch the** Introductory Video to understand the program's goals, structure, and expectations.
2. **Complete the Food As Medicine Questionnaire** on page 3 of this referral form

Both steps must be completed prior to submitting a referral.

PLEASE FAX COMPLETED FORM, QUESTIONNAIRE, AND ANY ATTACHMENTS

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Food As Medicine Questionnaire

This questionnaire is to be completed by the patient. Please include the completed questionnaire along with the referral form and any other attachments. Thank you.

Name: _____

1. This group medical program lasts for 8 consecutive weeks, followed by a group follow-up session 4 to 8 weeks after the final session. Each weekly appointment is 90 minutes long. Participation requires a full 8-week commitment, including attending all sessions, completing blood work, and following the recommended treatment protocol to the best of your ability.

   Do you agree to these requirements?

   Yes ❑ No ❑

2. As part of this program, the doctor will be recommending various lifestyle adjustments. For example, anti-inflammatory modifications to nutrition, sleep optimization, stress management, and optional supplements will be recommended. Budgetary differences will always be respected and taken into consideration.

   Are you willing to implement any lifestyle adjustments that may be recommended?

   Yes ❑ No ❑

3. **I certify that I have watched the Introductory Video and understand the requirements of the program.**

   Signature: _____ Date: _____

We very much appreciate your time and willingness to complete this questionnaire.

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