mind mood
Clinical Care Network

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

REFERRAL FORM Yoga Therapy

Thank you for your referral to our Yoga Therapy program for individuals with diagnosed health conditions. This 9-week program includes weekly 90-minute online group sessions. All patients will be scheduled for a consultation prior to acceptance. This program does **not** manage medications.

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: _____

Eligibility criteria

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

- ❑ Patient has a diagnosed medical condition including but not limited to anxiety disorders, mood disorders, chronic pain, chronic fatigue, diabetes, hypertension, obesity, fibromyalgia or osteoarthritis
- ❑ Patient does not have active or persistent psychosis
- ❑ Patient is not an acute safety risk for suicide or self-harm
- ❑ Patient does not have an active eating disorder
- ❑ Patient does not have moderate to severe autism spectrum disorders, intellectual disability, or cognitive impairment interfering with their ability to engage in therapy
- ❑ I have discussed this referral with this patient
- ❑ In my opinion, this patient is prepared to make significant changes to improve physical and mental health

PLEASE FAX COMPLETED FORM AND ANY ATTACHMENTS TO 1-833-333-1809

Canadian Mental Health Association
British Columbia
Mental health for all