RECONNECT
MENTAL HEALTH

Reconnect Mental Health
Phone: 1-403-527-8468
Fax: 1-587-824-2606
Website: reconnectmentalhealth.com

Patient Name: _____ **Date of Birth:** _____

PHN: _____ **Practitioner:** _____

Address: _____ **PRACID:** _____

Phone: _____ **Phone #:** _____

Email: _____ **Fax #:** _____

PATIENT EMAIL ADDRESS IS REQUIRED

or will automatically be declined

Group Therapy with Psychiatric Management Referral Form

Patient Eligibility (must meet all criteria)**:**

- ☐ Age 18-65
- ☐ Resident of Alberta, in the South Zone (Red Deer and south)
- ☐ Moderate to severe anxiety or depression symptoms, but not requiring a higher level of care such as case management
- ☐ Willing and able to commit to weekly virtual group therapy sessions (there is a no-show fee of $50 per missed session). There are no group sessions in July/ August months
- ☐ Have failed at least 3 antidepressant trials (non-response or intolerance)
- ☐ Depression and anxiety symptoms deemed not primarily caused by substance use
- ☐ No severe active substance use issues and not actively suicidal (requires higher level of care)
- ☐ No primary psychotic illness or bipolar I disorder
- ☐ No history of violence/ physical assault towards others
- ☐ If personality vulnerabilities present, patient is deemed suitable for virtual group, has clear goals and is willing to grow and commit to the group

Referral must include **both** of the following to be processed:

- ☐ a recent clinical note pertaining to the reason for referral
- ☐ previous psychiatric consult notes (if available)
  - ☐ (if applicable) patient is under the care of psychiatrist Dr._____

Clinical background (personality traits, suicidality, diagnosis, comorbidities, patient goals):

_____

_____

_____

_____

_____

Referring physician agrees to continue their care once patient has completed treatment at Reconnect Mental Health

Primary Care Provider Signature: _____ Date_____