Referral To: ☐ **Mindful Cognitive- Behaviour Therapy Group**
Community Mental Health Program, Toronto Western Hospital
399 Bathurst St., East Wing, 9th Floor, Ontario M5T 2S8
Please forward to: Beta or Paul at (416) 603-5747 Fax: (416) 603-5490

MCBT Group Referral Form (please print and complete all areas)

Client Name:	Mrn# (if available)
Address:	Phone#:
	Email client:(intake only)
D.O.B:	Health Card#:
Referred By:	Family Physician:
Phone#: Fax#:	Phone#: Fax#:
Address:	Address:
Date of Referral:	

***We ask that the referring professional be available to the client for therapeutic support if the need arises. This is a DAYTIME Programme.**

Client History:
Psychiatric Diagnosis: (if available)
Medications:

	No	Yes (please qualify)
Current Substance Abuse: If **yes,** amount & frequency&substance used:		
Acutely Suicidal:		
Criminal/Legal Issues Pending:		
History of Violent/Aggressive Behaviors:		
History of Psychosis:		
Flashbacks/PTSD. Symptoms:		

FOR OFFICE USE ONLY

Comments:	
Client Contact	
Appointment Given:	