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| **GREY NUNS COMMUNITY HOSPITAL**  **MENTAL HEALTH/PSYCHIATRY**  **OUTPATIENT GROUP THERAPY REFERRAL** | Please check the desired group(s):  **POP**  □ Group Therapy Program - 12 weeks (Tues-Fri)  □ Emotion Regulation Group - 12 weekly sessions  Fax 780-735-7298  **PPHP**  □ Group Therapy - 6 weeks (Monday – Friday)  □ Case management  □ Anger Group - 12 weekly sessions  Fax 780-735-7809  **All information is required to process the referral.** |
| **Name: Address:** | |
| **Telephone: Home Work Cell** | |
| **D.O.B. P.H.N.** | |
| **Referred by: Profession:** | |
| **Address: Telephone:** | |
| **Diagnosis:**  **AXIS I: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AXIS IV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **AXIS II: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AXIS V: GAF \_\_\_\_\_\_\_\_\_\_\_**    **AXIS III: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Reason for referral at this time (i.e. current stressors, change in functioning, etc.)** | |
| **Past Treatment: □ Inpatient admissions □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **□ Outpatient programs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **□ Community therapy** | |
| **Present Treatment: (Medications, Psychosocial, etc.)** | |
| **Will you be providing follow up care on discharge? □ Yes □ No If no, alternate follow up plans:** | |
| **Date: Signature:** | |