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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 sessionsFax 780-735-7298**PPHP** □ Group Therapy - 6 weeks (Monday – Friday) □ Case management□ Anger Group - 12 weekly sessionsFax 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:** |