Mindfulness West
Evidence Based Practice

Referral Form

Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy (MBCT) is an evidence-based group program developed for prevention of depressive relapse. Participants who may benefit are adults with a history of recurrent depression or who are experiencing residual depression, mild-moderate acute depression, anxiety and/or stress.

MBCT combines cognitive-behavioural therapy (CBT) and mindfulness meditation practices. Participants will apply tools and techniques that focus on prevention and self-care, while developing awareness of the habitual cognitive patterns that can trigger a depressive episode or anxiety response.

The MBCT program is an 8 week course: a 2-hour group session each week + "homework" for 45-60 min per day.

All participants should have a family physician or qualified mental health counsellor involved in their care, as the MBCT facilitators will not be primary mental health care providers for patients enrolled in the program.

To refer a patient, please complete both pages of this form and fax to 250-940-3611.

For more information about Mindfulness West, MBCT & the referral process, go to:
www.mindfulnesswest.ca
Questions?: Please contact us at mindfulnesswest@outlook.com

Patient Information

First Name: _____ Date of Birth: YYYY_____MM_____DD_____

Last Name: _____ Email: _____

Address: _____ Phone: (_____)_____

_____ Care Card #: _____

City: _____ Province: _____

Postal Code: _____

Chief Complaint / Diagnosis / Current Mood:

_____

_____

Relevant Medical History:

_____

_____

_____

_____

Complete both pages

PHQ- 9 Score *(required):* _____

Medications:

_____

_____

Exclusion criteria for MBCT generally include:

- moderate-severe depression (PHQ-9 score >14)
- acutely suicidal
- bipolar disorder
- psychosis
- severe symptoms of PTSD
- social anxiety that would interfere with group attendance
- substance use that would interfere with group-based learning
- personality disorders that would interfere with group process
- *any other condition that would be adversely affected by participation in the group or by intensive meditation practice.*

Please provide details of any known Contraindications or Precautions:

_____

_____

Referral Source Information

First Name: _____ Referral Date: _____

Last Name: _____ Fax: (_____)_____

Organization: _____ Phone: (_____)_____

Address: _____ Email: _____

_____ Designation (e.g. MD, NP): _____

City: _____ Province: _____ Specialty (if applicable): _____

Postal Code: _____ Billing #: _____

Please submit an MSP 03333 ("no charge referral") to Dr. Marisa Collins #07067

Send completed referral form to:

Westshore AVI Health Centre

111-2787 Jacklin Rd. Langford BC V9B 3X7

Fax: 250-940-3611