TeleCBT Referral Package

We have made updates to our clinic's referral system; aimed at enhancing the appropriateness of our services for patients, matching providers with patients more effectively, and decreasing patient wait times. **All incomplete referral packages are automatically rejected**.

Seven steps

1. Please ensure your patient is an appropriate referral (see TeleCBT's exclusion criteria below)—and that they know they're being referred.
2. Please complete and send the following: a) two-page referral form; b) PHQ-9; c) GAD-7 d) copy of the cumulative patient profile.
3. Please fax your completed referral package to 289-203-1178 (one referral per fax transmission).
4. Your package will be reviewed to confirm completion—and that the patient's issue falls within TeleCBT's Scope of Practice. If the referral isn't appropriate, you'll be notified by fax; the patient won't be contacted.
5. A TeleCBT staff will make two attempts to reach your patient (c/o email and/or phone). IMPORTANT: Intake workers call from a number with no caller ID.
6. You will receive a fax that will either confirm your patient's on TeleCBT's OHIP waiting list—or that we couldn't reach your patient.
7. Your patient goes for an OHIP-mandated in-person first visit to establish a patient-physician relationship. Patients must be willing to visit one of our seven offices for their first visit: Toronto, Ottawa, Markham, Burlington, London, Kitchener/Waterloo, or Kanata. Exceptions may be made for those more than 1.5hr from one of the listed locations.

TeleCBT's non-negotiable exclusion criteria

1. TeleCBT does not offer psychiatric assessments/diagnoses or medication management.
2. TeleCBT does not treat bipolar disorder, borderline personality disorder (BPD), psychosis (e.g., schizophrenia), trauma and/or post-traumatic stress disorder (PTSD), suicidal ideation, recent suicide attempts, or mental health challenges requiring hospitalization within the past year.
3. TeleCBT is not suitable for individuals experiencing a crisis or in need of urgent care. Such patients should be directed to the nearest emergency department.

NOTE: Some TeleCBT services might contribute to outside use.

TeleCBT Referral Package

Date	Fax completed form to 1.289.203.1178

Patient info

First name	Last name	Preferred name *(if different)*	Pronouns

DOB *(MM/DD/YYYY)*	OHIP #	V code	Exp. date *(MM/DD/YYYY)*

Phone #	Alternate phone #	Email

Address	City	Postal Code

Your patient will be contacted via phone and/or email to arrange their initial appointment

Primary diagnosis

Please choose all that apply		Details
☐anxiety (e.g., GAD)	☐OCD	
☐anger issues	☐Phobias	
☐chronic pain	☐Postpartum	
☐depression *(unipolar only)*	☐relationship issues	
☐dysphoria	☐self-esteem	
☐Grief	☐social anxiety	
	☐stress management	

The TeleCBT OHIP Scope of Practice excludes the following: bipolar disorder, borderline personality disorder (BPD), psychosis (e.g., schizophrenia), trauma and/or post-traumatic stress disorder (PTSD), suicidal ideation (suicidal thoughts with a plan and means), suicide attempts within the past year, and mental health challenges for which hospitalization was required within the past year.

Risks

This information is used to determine patients' eligibility and to ensure their safety and the safety of our staff

Risk	yes	no	mm/dd/yyyy	details
Suicide attempt/ideation	☐	☐		
Self-harming behaviours	☐	☐		
Anger issues/violent behaviour	☐	☐		
Substance use	☐	☐		

Logistics

Preferred location for the OHIP-required in-person first visit?

Toronto	*Ottawa*	*Markham*	*Burlington*	*London*	*Kitchener/Waterloo*	*Kanata*
☐	☐	☐	☐	☐	☐	☐

Preferred therapy format ☐group ☐individual ☐unsure ☐both

Does your patient have extended health benefits? ☐yes ☐no ☐unsure

Patient considerations:

☐Cognitive impairment	☐Visual impairment	☐Hearing impairment	☐65+ household

Convenient, confidential online counseling. We can help.

If you have questions, please contact us: info@telecbt.ca www.telecbt.ca

TeleCBT Referral Package

Patient name (please repeat)

History
Past mental health care (provide names of practitioners, if known)
Diagnoses (physical & psychiatric)
Medications
Psychiatric hospitalization within the past 12 months (if yes, provide details)

Referring physician	
Name	**Address**
Phone #	**Fax #**
OHIP billing #	**Signature**

TeleCBT Referral Package

Patient name (please repeat)

PHQ-9		0	1	2	3
Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	*Little interest or pleasure in doing things*	☐	☐	☐	☐
2	*Feeling down, depressed or hopeless*	☐	☐	☐	☐
3	*Trouble falling or staying asleep, or sleeping too much*	☐	☐	☐	☐
4	*Feeling tired or having little energy*	☐	☐	☐	☐
5	*Poor appetite or over eating*	☐	☐	☐	☐
6	*Feeling bad about yourself—or that you are a failure or have let yourself or your family down*	☐	☐	☐	☐
7	*Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐	☐	☐
8	*Moving or speaking so slowly that other people could have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐	☐	☐
9	*Thoughts that you would be better off dead or of hurting yourself in some way*	☐	☐	☐	☐
Scoring: 0-4 (none), 5-9 (mild), 10-14 (moderate) 15-19 (moderately severe), 20-27 (severe)					

GAD-7		0	1	2	3
Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	*Feeling nervous, anxious or on edge*	☐	☐	☐	☐
2	*Not being able to stop or control worrying*	☐	☐	☐	☐
3	*Worrying too much about different things*	☐	☐	☐	☐
4	*Trouble relaxing*	☐	☐	☐	☐
5	*Being so restless it is hard to sit still*	☐	☐	☐	☐
6	*Becoming easily annoyed or irritable*	☐	☐	☐	☐
7	*Feeling afraid as if something awful might happen*	☐	☐	☐	☐
Scoring: 0-4, 5-9 (Mild), 10-14 (Moderate), 15-21 (Severe)