TeleCBT Group Therapy Referral Form

This form is for CBT group therapy **ONLY**. Incomplete forms will be declined.

Date	**Fax completed form to 1.289.203.1178 | ATTN: GROUPS**

Eligibility & Exclusion Criteria

TeleCBT group programs are designed for adults with mild-moderate illness severity. To ensure participant safety and appropriate therapeutic fit, TeleCBT group therapy is not suitable for individuals currently experiencing:

- Active psychosis or mania
- Active suicidal ideation or recent suicide attempt
- Mental health challenges requiring hospitalization within the past year

TeleCBT is **not appropriate** for individuals experiencing a **crisis** or requiring **urgent care**. Patients in crisis should be directed to the nearest emergency department.

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**

**An active email address is required to access video component of virtual CBT group therapy.*

Risks

This information is used to determine patients' eligibility and to ensure their safety and the safety of staff and other group participants.

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

History

Past mental health care (*therapy, psychiatry, counselling, etc.*):

Has a psychiatric hospitalization occurred more than 12 months ago? (*if yes, provide details*):

Other relevant information (*previous diagnosis, medications, etc.*):

Referring physician

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

Convenient, confidential online counseling. We can help.

www.telecbt.ca groups@telecbt.ca 888.468.6178 ext. 17 289.203.1178