PATIENT REFERRAL FORM FOR VIRTUAL CBTm CLASSES

Shared health Soins communs Manitoba

PATIENT INFORMATION

First Name _____

Last Name _____

PHIN _____

Date of Birth _____

Phone Number _____

Email _____

Primary Care Provider _____

REFERRING SITE INFORMATION

Referring Site _____

Contact Name _____

Phone & Fax _____

Indicate stream: Facilitator-led (Zoom) ☐ OR Web-based (self-directed) ☐

When CBTm completed, where should we direct patient for follow-up?

Referring Site ☐ OR Primary Care ☐

CBTm

COGNITIVE BEHAVIOUR THERAPY WITH MINDFULNESS

THÉRAPIE COGNITIVO-COMPORTEMENTALE DE LA PLEINE CONSCIENCE

CBTm Team Contact Info:

www.cbtm.ca

cbtm@umanitoba.ca

Tel: (204)787-7729

Fax: (204)789-2819