BounceBack® reclaim your health

bouncebackontario.ca | 1·866·345·0224

Canadian Mental Health Association Ontario

Ontario

Funded by the Government of Ontario

Please send referral information to your BounceBack team via fax: (905) 430-1768

PRIMARY CARE REFERRAL FORM

All fields must be filled out

BounceBack® is a free program for individuals aged 15 years and over experiencing mild to moderate depression, with or without anxiety. Community coaches provide telephone delivery of a brief, workbook-based, self-help program to improve mental health.

Referrer: ☐ Primary care provider (doctor, nurse practitioner) ☐ Psychiatrist ☐ Self-referral

Patient name: ____________________ Gender: ____________

Date of birth: ____________ (MM / DD / YYYY)

Phone (Home): ____________________

Phone (Mobile): ____________________

Easiest way to contact:

☐ Email ☐ Telephone ☐ Text

Address: ____________________ City: ____________

Postal code: ____________ Email: ____________________

Can a confidential message be left at this number? ☐ Yes ☐ No

MOA: Please apply patient address label or print legibly

THIS SECTION MUST BE COMPLETED IN ORDER FOR THE REFERRAL TO BE PROCESSED

1. Is the individual:

Yes No

☐ ☐ Capable of engaging with and concentrating on CBT materials?

☐ ☐ Actively suicidal or has tried to commit suicide in the past 6 months?

☐ ☐ At high risk to harm self or others?

Yes No

☐ ☐ Experiencing acute mania or psychosis?

☐ ☐ Diagnosed with a personality disorder?

☐ ☐ Significantly misusing drugs or alcohol to the extent that it would impact engagement in CBT treatment?

☐ I confirm that this referral is not being sent directly from a hospital emergency department or in-patient psychiatric unit.

Please note that the primary healthcare practitioner always retains professional responsibility for the patient.

2. Please include the Patient Health Questionnaire (PHQ-9) score:

(see reverse for PHQ-9)

3. We offer coaching in several languages other than English; please identify the preferred language of your patient:

____

4. Is the individual receiving medication for:

Depression? ☐ Yes ☐ No

Anxiety? ☐ Yes ☐ No

Primary Care Practitioner information:

Name: ____________________

Address: ____________________

Phone: ____________ Fax: ____________ CPSO# (or CNO#): ____________

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PHQ-9 - Please ask the patient the following:

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	______	+ ______	+ ______	+ ______
			= total score:	______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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BB PHQ screen (2018-02-15)