



Referral Form: Introductory Mindfulness Program

This form is optional—we accept referrals in any format

Fax: 647-350-5446 – Attn Dr. Susitna Banerjee

PATIENT DEMOGRAPHICS:

Patient Name (Last, First) _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ Phone: _____

Email address: _____ Health Card (incl VC): _____

REASON FOR REFERRAL (must check both):

- ☐ For participation in virtual group mindfulness program (1 hour/week x 5 weeks, delivered virtually)
- ☐ Patient meets criteria (reviewed inclusion/exclusion criteria below)

Relevant Clinical Info (include past medical history and medications or attach CPP):

☐ See CPP attached

Inclusion Criteria	Exclusion Criteria
Patient age 18+, has OHIP, and a family physician Low-risk patients seeking help with one or more of: - Stress Management (<i>no diagnosis needed</i>) - Mild depression, anxiety - Mild sleep disturbance, insomnia - Chronic pain or ongoing physical symptoms Ex. (IBS, psoriasis, migraines, etc.) Patient able and willing to: - Attend all sessions virtually in Ontario (5 weeks, 1 hr/week) - Meditate for 10 min daily, keep a log, do readings	Suicidal ideations or related hospital visit in last 12 months Moderate to severe depression, anxiety, or social anxiety Alcohol and/or substance use disorder Bipolar Disorder, mania Schizophrenia, psychosis Active PTSD, OCD, or eating disorder Personality Disorders Neurological impairment (e.g. brain injury with sequelae, cognitive impairment, uncontrolled seizures) Unable to tolerate intense emotions like sadness, anxiety, or anger

REFERRING PHYSICIAN INFORMATION:

Physician Name: _____ Phone #: _____ Fax #: _____

OHIP Billing #: _____ Signature: _____ Date: _____

Family Physician Name: _____ ☐ Same as referring physician