Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge
Mental health for all

Group Referral Form

Date:

Client Name:

Date of Birth:

Phone #: **E-mail:**

Preferred Method of Contact:

Can Workers Leave a Message? ☐ **Yes** ☐ **No**

Referral Source:

Mental Health Diagnosis and/or Symptoms:

Special Considerations:

Please select which group(s) you are interested in:

- ☐ **Changeways**
- ☐ **Youth Changeways**
- ☐ **Cognitive Behavioral Therapy (CBT) Skills** *previous CBT experience required
- **Dialectical Behavior Therapy (DBT) Skills**
  - ☐ **Full 14-week program**
  - ☐ **Mindfulness ONLY**
  - ☐ **Distress Tolerance ONLY**
  - ☐ **Emotion Regulation ONLY**
  - ☐ **Interpersonal Effectiveness ONLY**

Please submit referral to IntakePTBO@cmhahkpr.ca

Office Use Only		
Date Referral Received:	Added to Waitlist: ☐Yes ☐No	Entered into CRMS: ☐Yes ☐No
Date of Contact:	Contacted By:	Client Confirmation: ☐Yes ☐No
Message(s) Left:		
Comments:		