Physician Referral Form

To Whom It May Concern:

Please accept this request from your patient to participate in the Roots to Thrive program.

Roots to Thrive consists of 12 weekly virtual facilitated meetings (referred to as a Community of Practice) that offer resiliency knowledge, skills and practice in a supportive community for individuals experiencing mental distress. It is not group therapy. Over 20 medical professionals are collaborating to run this program. This includes a holistic intake assessment overseen by our lead psychiatrist.

The following article, Published in Frontiers of Psychiatry Journal, provides further information on program design and outcomes to date.

https://www.frontiersin.org/articles/10.3389/fpsyt.2021.803279/full?utm_source=F-NTF&utm_medium=EMLX&utm_campaign=PRD_FEOPS_20170000_ARTICLE

PLEASE NOTE: If the patient has a mental health diagnosis, refer based on that diagnosis (if it aligns with the eligibility criteria as listed below). If the patient has not been assigned a diagnosis, please describe the patient's specific challenge(s), which will then be assessed by our intake team prior to entering the program.

If you have any questions, please email us at julia@rootstothrive.com with 3 specific days and times you are available for one of our clinicians to follow up. We will email you in response to let you know which day and time.

When the referral form below is completed, please fax to 250-244-8426 (confidential) or email to navigator@rootstothrive.com. INCOMPLETE REFERRALS WILL BE DECLINED.

Name: _____ Gender: ☐ M ☐ F ☐ U ☐ O

Surname First name

Address:_____

Street City Postal Code

DOB: _____ PHN: _____

(MM/DD/YYYY)

Preferred Phone: _____ Email:_____

Alternate Contact: _____ Phone: _____

Health Care Provider (HCP): _____ Phone:_____

Referring HCP: _____ Phone:_____

Fax: _____

HCP Signature: _____HCP's Billing #: _____ Date: _____

Exclusion Criteria:

- Presence of active psychotic symptoms
- Diagnosis of dementia or delirium
- Inability to tolerate group work
- Extreme emotional instability

Provisional Diagnoses: past and present (mark all that apply)

- ❑ Treatment Resistant Depression
- ❑ Obsessive Compulsive Disorder
- ❑ Post-Traumatic Stress Disorder
- ❑ Generalized Anxiety Disorder
- ❑ Adjustment Disorder

- ❑ Substance Use Disorder

AND/OR

Concurrent Challenges (separate from a formal/ongoing mental health diagnosis)

- ❑ Unresolved Grief
- ❑ Suicidal Ideation
- ❑ Sleep Disorders
- ❑ Chronic Pain
- ❑ History of Psychiatric in-patient admissions (please specify with dates):
  _____
- ❑ Current or recent out-patient psychiatric care (please specify):
  _____
- ❑ Any history of self-harm behavior (please specify):
  _____
- ❑ Other:
  _____

Treatments tried (psychotherapy and pharmaceutical) for mental health condition with dates:

_____
_____

Personal Mental Health/Substance Use History:

_____
_____

Family Mental Health and Substance Use History:

_____
_____

Current Medications: - Noting but not limited to:

- ❑ Benzodiazepines _____
- ❑ Lamotrigine _____
- ❑ Psychostimulants (including ADHD medications) _____

- ❑ MAOIs (Phenelzine, Selegiline) _____
- ❑ Antidepressants (venlafaxine, bupropion, desipramine) _____
- ❑ Calcineurin inhibitors (cyclosporine, tacrolimus) _____
- ❑ Corticosteroids _____
- ❑ Estrogens _____
- ❑ Midodrine _____
- ❑ NSAIDS (ASA, ibuprofen, naproxen, diclofenac, celecoxib, etc) _____
- ❑ Testosterone _____
- ❑ Triptans _____
- ❑ Other **(please list all other medications):**

  _____

  _____

Any accessibility or physical challenges?

- ❑ Ambulatory aids
- ❑ Ostomy Bags
- ❑ Disabilities
- ❑ Other (please specify):

_____

_____

The Roots to Thrive program is not a substitute for ongoing medical care. This will remain with the referring provider.

Name: _____

Designation: _____

Signature: _____

Date: _____