Moves for Mind and Mood - Referral Form

Referring psychiatrist information

Name:

MSP Number:

Office Address:

Office Phone:

Office Fax:

Patient information

First Name: Last Name:

MSP: Date of Birth:

Sex: Pronouns:

Phone: Email:

Address:

Medical information

Psychiatric Diagnosis:

For acceptance into this program, the patient must have a diagnosis of a mood disorder or an anxiety disorder.

Medical Diagnosis:

Current Medications:

Referral checklist

By signing below, I confirm that:

1. This patient does **not** have an active medical disorder or condition that would preclude them participating in 90 minutes of mild to moderate physical activity. (The MOVES FOR MIND AND MOOD program requires participating in this level of activity.)
2. If this patient is actively suicidal, or has symptoms of mania or psychosis, the patient has been psychiatrically stabilized. (Patients who have not been psychiatrically stabilized are not able to participate effectively in MOVES FOR MIND AND MOOD.)
3. If this patient is taking prescribed psychiatric medications, the medications will continue to be managed by me or by another medical professional. (The MOVES FOR MIND AND MOOD program does not include medication management.)

Physician's signature: _____ Date: _____

All referred patients will be scheduled for a consultation with Dr. McBain. We are not able to guarantee that all referred patients will be accepted into the program.

PLEASE FAX COMPLETED FORM AND ANY ATTACHMENTS TO MDABC at 1-866-821-5992