# BounceBack® reclaim your health

## Practitioner Referral Form

Canadian Mental Health Association
*Mental health for all*

Association canadienne pour la santé mentale
*La santé mentale pour tous*

www.cmha.ca/bounce-back | 1-855-873-0013
bounceback@cmha.ca

**IMPORTANT NOTE: All fields must be completed to process the referral.**
The participant will be contacted within 5–10 business days of receiving the referral form.

**BounceBack® is a free program for individuals aged 15 years and over experiencing anxiety and/or mild to moderate depression (PHQ-9 score is 21 or lower). Coaches provide telephone delivery of a brief, workbook-based, self-help program to improve mental health.**

### Participant information

Name: _____ Gender: _____

Date of birth: _____ (MM/DD/YYYY) Phone: _____ ❑ Home ❑ Mobile

Address: _____

City: _____ Province: _____

Postal code: _____ Email: _____

Best way to contact participant: ❑ Email ❑ Phone

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

**Parent/guardian contact information** *(for adolescents age 15–18 only)*

Name: _____

Relationship: _____

Email: _____ Phone: _____

### Primary Care Provider

Name of clinic: _____

Referrer name: _____

❑ Physician
❑ Psychiatrist
❑ Nurse Practitioner

Address: _____

Phone: _____

Fax: _____

Email: _____

**Please note** that the referring care practitioner always retains clinical responsibility for the participant, which may include assessing suicide risk and ensuring that appropriate follow-up and treatments are provided. The referring care practitioner is also responsible for informing the patient if they are ineligible for the program.

### 1. Please confirm that the participant:

- ❑ 15 years of age or older, currently living in Canada
- ❑ Primary care provider listed accepts clinical responsibility for the participant during the program (physician, nurse practitioner and psychiatrist)
- ❑ Is not significantly depressed / PHQ-9 score is 21 or lower (PHQ9 score required to process referral.)
- ❑ Is not at risk to harming self or others
- ❑ Is not significantly misusing alcohol or drugs to the extent that would impact engagement in CBT treatment
- ❑ (If aged 19+) Is not diagnosed with a personality disorder
- ❑ Has not had manic episode or psychosis in last 6 months
- ❑ Is capable of engaging with and concentrating on workbook materials

### 2. Participant's PHQ-9 score: (PHQ9 score required to process referral.)

PHQ-9 score: _____ #9 score: _____

### 3. Is the participant receiving medication for:

❑ Depression ❑ Anxiety

### 4. Please indicate the participant's preferred language for telephone coaching:

❑ English ❑ French

**Please transmit referral information to Bounce Back® fax: 855-962-2378**

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**Please include the PHQ-9 total score on the first page. You do not need to submit this page with your referral. To determine the PHQ-9 please ask the participant 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. Feeling down, depressed, or hopeless | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 2. Trouble falling or staying asleep, or sleeping too much | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 3. Little interest or pleasure in doing things | 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 others notice? 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



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