Referral Form: Ontario Structured Psychotherapy North Simcoe Muskoka

Service Description
People in Ontario can now access publicly funded cognitive-behavioural therapy services (CBT) through **Ontario Structured Psychotherapy (OSP)**. CBT is goal-oriented, time-limited treatment that helps clients by teaching practical skills and strategies to manage their mental health and improve quality of life. OSP includes services with **both higher and lower levels of clinician involvement** as part of its stepped care model. Most clients will begin treatment with less intensive service (such as telephone coaching with workbooks) and be "stepped up" to services with more therapist contact, if needed. Some services are for adults and youth age 15+; structured one-to-one psychotherapy is only available for adults age 18+. A referral from a primary care provider (family doctor or nurse practitioner) is preferred to access the service. **Please fax this referral form to the OSP Intake Team based at Waypoint: (705) 549-7330.**

Please note that OSP is not a crisis or emergency service.
If your client/patient is in need of immediate help, please direct them to the nearest Emergency Department or call 911

Eligibility Criteria	Yes	No
- **Client has a primary concern of anxiety, depression, or anxiety-related problems** (e.g., posttraumatic stress; test anxiety; work stress)	☐	☐
- T**he PHQ-9 & GAD-7 symptom screeners on page 4 are completed (they must be sent with the completed referral form**)	☐	☐
Client resides in Ontario	☐	☐
The circumstances below indicate that this program would NOT be suitable for a client's needs. Please check all items that apply to this client:	**Yes**	**No**
Client is actively suicidal and with impaired coping skills and/or has attempted suicide in the past 6 months	☐	☐
Client poses a high risk to themselves, risk to others, or are at significant risk of self-neglect	☐	☐
Client is self-harming, which is the primary concern	☐	☐
Client is experiencing significant symptoms of mania or hypomania currently or has experienced these symptoms within the past year*	☐	☐
Client is experiencing significant symptoms of a psychotic disorder currently or has experienced these symptoms within the past year*	☐	☐
Client has a severe/complex personality disorder that would impact their ability to actively participate in CBT for anxiety or depression. NOTE: This program is not appropriate for clients for which personality disorder is the main problem descriptor (i.e., problem that is currently causing the most distress and impairment)	☐	☐
Client has requested only medication management	☐	☐
Client has moderate to severe impairment of cognitive function (e.g. dementia or acquired brain injury); or moderate/severe impairment due to a developmental disability or learning disability	☐	☐
Client currently has problematic substance use or has had problematic substance use in the past three months that would impact their ability to actively participate in CBT. Client requires specialized concurrent disorders treatment.	☐	☐
Client has a **severe** eating disorder that would impact their ability to actively participate in CBT for anxiety or depression	☐	☐
**This does not include symptoms induced by medication or substance use*		

Client Information *Please note that incomplete referrals will result in delays in serving clients, as the screening process requires all information to be provided prior to proceeding.*

Name (last, first): ________________________________Date of Birth (YYYY/MM/DD): _______________

Preferred Name: ________________________________ Preferred Pronoun: _______________________

Address: ____

City: ____Postal Code: ____________________________

Preferred Contact #: ___________________________ Can a message be left at this number? ☐Yes ☐No

Alternate Contact #: ___________________________ Can a message be left at this number? ☐Yes ☐No

Email address: ____

Health Card #: __________________________________ Version Code: _________________

Main spoken language? ☐English ☐French Other: ______________________________

Has the client been connected with any community services (past or present)?

Please list: ____

Referral Source Information

Provider's Name (last, first): ____________________________Telephone #: ____________________

Type: ☐Family Physician ☐Nurse Practitioner ☐Psychiatrist

☐Other (e.g., Psychologist, Social Worker, RP): ____

OHIP Billing number: ____________________ Signature: _____________________________________

Organization Type (e.g. FHT, CHC, solo practice, hospital):_______________________________________

Address: ____

Email: ____________________________________ Fax #: ____________________________________

Preferred method of contact: ☐ Telephone ☐ Fax ☐ Email

Date of Referral (YYYY/MM/DD): ___________________________

Primary Care Provider (if different than Referral Source)

Provider's Name (last, first): ______________________________Telephone #: ____________________

Fax: ______________________Organization Name (e.g. FHT, CHC):_____________________________

Is primary care provider aware of this referral? ☐Yes ☐No

Is primary care provider agreeable to this referral? ☐Yes ☐No

Check box if client does NOT have a primary care provider: ☐

Consent

Is the client aware of and have they consented to this referral? ☐Yes ☐No

Please be aware that information provided on this referral form may be used for both treatment and quality assurance purposes in OSP.

Your submission of this Referral Form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information contained to Waypoint Centre for Mental Health Care and the OSP service providers. If applicable, please include your Organization's Consent to Release of Personal Health Information Form.

Information Regarding Client's Situation

Probable problem descriptors (check all that apply):

☐ Depression and low mood	☐ Specific fears
☐ Generalized anxiety and worry	☐ Health anxiety
☐ Social anxiety and performance fears	☐ Posttraumatic stress
☐ Obsessive-compulsive concerns	
☐ Unexpected panic attacks and related fears (e.g., agoraphobic fears)	☐ Other anxiety and stress related problems (e.g., work stress, test anxiety, etc.)

Which of these is the most disabling problem currently? ____

Brief description of presenting problem/reason for referral (specify current symptoms, environmental stressors, level of urgency, and history; attach report, if available): ___________________________________
____
____
____

Duration of problem(s): ☐ 0 to 3 months ☐ 4 to 12 months ☐ More than 12 months

Functional impact: ____
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____

Referral Form Completed By:

_____________________________________ __________________________ ____________________

(Print name and credentials) (Signature) (Date YYYY/MM/DD)

Patient Health Questionnaire (PHQ-9)

During the **last 2 weeks**, how often have you been bothered by any of the following problems?

Problem	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	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 TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around 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 problem on this questionnaire so far, 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

Generalized Anxiety Disorder Assessment (GAD-7)

During the **last 2 weeks**, how often have you been bothered by any of the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: ________________

Information Sheet for Clients & Practitioners

(**Please give this sheet to clients when a referral is being made to OSP**)

What to expect after a referral has been sent:

- Upon receipt of this referral, the client will be contacted by telephone to gather additional information for screening purposes.
- The screening clinician will make up to 2 attempts to contact the client, and if no contact can be made the file will be closed and a letter will be sent to the referral source alerting them to the outcome.
- If, following that screening, it is determined that OSP may be appropriate for the individual, the client will be booked for an appointment for a Clinical Intake and Triage assessment that will be done over the telephone and will take approximately 60-90 minutes. This assessment does not guarantee that the client will be provided treatment within OSP, as the purpose of the assessment is to: 1. Confirm the main presenting problem, 2. Confirm appropriateness of OSP for the client's needs, and 3. If OSP seems appropriate, then identify the best treatment type within OSP.
- The main problem areas that are currently in scope for treatment in OSP are: Depression and low mood; Generalized anxiety and worry; Health anxiety; Unexpected panic attacks and agoraphobic fears; Social anxiety and performance fears; Specific fears; Obsessive-compulsive concerns; Posttraumatic stress; and other anxiety and stress related problems (e.g., work stress, test anxiety).
- Most individuals who are enrolled in OSP will start out with less clinician involvement (e.g., receiving up to 6 sessions of telephone coaching while working through a workbook related to the client's presenting concern).
- If that treatment does not appear to be helping the client, they may be stepped up to cognitive behavioural psychotherapy (CBT) that typically involves up to 8 to 12 weekly sessions with a therapist. This service is only available to adults age 18+. CBT is a goal-oriented, time-limited therapy that helps clients by teaching practical skills and strategies to manage their mental health and improve quality of life.
- In cases where OSP is deemed to be not appropriate for a referred client's needs, the OSP team will attempt to recommend a more appropriate service for the client and communicate that recommendation to the referrer.
- OSP offers short-term treatment but does not offer long-term treatment and follow-up. All clients will be referred back to their referrer for additional long-term follow-up, as needed.