BC Virtual Mental Health Practice

Referral Form for Group or Individual Treatment Programs

NORMAN STEINHART BSC MD MDPAC(C)
EMAIL: DRSTEINHART@GMAIL.COM
TELEPHONE: (604) 841-1270
FAX: (778) 309-6371

Please note: Group or individual treatments are NOT suitable for patients who are at risk of self harm or harm to others, or are currently experiencing an episode of major depression, bipolar disorder, post traumatic stress disorder (PTSD), or have emotional dysregulation, including borderline personality disorder. Group programs do not provide psychotherapy for specific acute or chronic mental disorders, but are intended to provide general help with excessive stress and/or chronic illness.

Requirements for Treament

All patients will require:

- A stable internet connection
- A private place to connect
- Willingness to participate in virtual treatments without in-person contact

For **group treatments** only, patients must be willing to:

- Commit to an 8-week program of 90-minute sessions
- Practice the methods and techniques taught for 10-20 minutes daily

To discuss referrals directly before or after submitting the referral form, please call (604) 841-1270.

Referring Physician Information

First Name: Last Name:

Address:

City: Postal Code:

Phone: Email:

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Patient Information

First Name: Last Name:

Address:

City: Postal Code:

Phone: Email:

DOB (dd/mm/yy): PHN:

Treatment Type Requested:

- ☐ Group Medical Visit- General Stress Reduction (MSP Covered)
- ☐ Group Medical Visit- Chronic Illness Coping and Stress Reduction (MSP Covered)
- ☐ Individual Medical Visit- Stress, Chronic Illness or Psychotherapy (Billed Privately)
- ☐ Assess and Recommend Optimum Type of Treatment

Current medications:

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Reasons for referral and diagnoses (please list all current diagnoses, and include supporting documentation if necessary):

☐ As the referring physician, I confirm that I will be available to discuss any clinical concerns that may develop during treatment. I will be able to provide or arrange further treatment or support to the patient if the need arises, as urgent/emergency treatment is NOT provided in this program.

Signature:

If I require further information or feel the treatment programs are not appropriate for your patient, I will contact you. Otherwise, I will contact the patient to arrange an initial virtual visit to discuss their symptoms, concerns, and the goals for treatment. I will inform you of the outcome of the visit, and whether the patient and I have agreed to start a treatment program.

Please fax the completed form to (778) 309-6371 OR
Password-protect the form and email to drsteinhart@gmail.com