Suite 1206, 750 West Broadway, Vancouver, BC V5Z 1K1
Suite 300, 3665 Kingsway, Vancouver, BC V5R 5W2 (mailing address)
Phone: 604-630-3071; Fax: 604-630-7062; Email: info@wisemindcentre.com; Website: www.wisemindcentre.com

Wise Mind Centre Referral Form

Before you fill out this form, please check our online booking page for information about clinicians currently accepting new clients. We try to update this page regularly. You may be able to book an initial appointment with some of our psychologists or non-registered clinicians using our online booking page. The link is https://wisemindcentre.janeapp.com/. When you book the appointment, please state the reasons for seeking the appointment.

Please return the form below if (1) you are not sure which clinician would be a better fit to what you need, (2) your preferred clinician is not available for online booking, and/or (3) you are seeking DBT (including DBT-informed therapy, skills group only, or comprehensive DBT service).

Date of Referral: ________________________

Referral Source (if self-referred, please skip to the next section)

Relationship to client: ____

First name: _______________________________ Last name: _______________________________

Phone: ____

Email: ____

Best time to call: ____

Is the client aware of your referral?_YES / NO

Client Information

First name: _______________________________ Last name: _______________________________

Parent name(s) if minor (under age 18): ____

Client date of birth: ______________________ Age: __________ Gender: __________________

Address: ____

City: __________________________________Province (required): _________________________

Phone (required): ____

Email (required): ____

Best time to call: ____

Ok to leave a message? (Circle one): YES / NO

Appointment availability (Circle all that apply): M / Tue / W / Thur / Fri / Sat

Morning / Afternoon / Evening

If the client is only available in the afternoon or evening for an appointment, what is the earliest appointment time they can make?

____

Does the client have extended health coverage? YES / NO / Unsure

Would the client be willing to see a master-level or doctoral-level clinician supervised by a registered psychologist for a reduced fee? YES / NO / Unsure

If the client is looking for a DBT skills group, what's their availability for group?

Adult skills group availability (Circle all that apply):

Tuesdays 4:30-6:30pm / Wednesdays 5:30-7:30pm / Thursdays 4:30-6:30pm

Multi-family adolescent skills group availability (Circle all that apply):

Wednesdays 4:30-6:00pm / Wednesdays 5:30-7:00pm

What types of service is the client seeking? (check all that apply)

_____ Individual therapy (any)

_____ Individual cognitive behavioral therapy

_____ Individual DBT-informed therapy

_____DBT multi-family adolescent skills group

_____ DBT adult skills group

_____ Comprehensive DBT (both individual DBT therapy and skills group)

_____ Couples or Family Therapy

_____ Unsure

How would you like this service be delivered?

_____ In-person _____ Online _____ No preference

If you are only interested in attending one of our skills groups, are you current seeing a clinician for individual therapy?   YES / NO

Please specify the type of clinician you are currently working with (E.g., psychiatrist, counselor, social worker, psychologist) and the frequency of your meeting (if applicable).

____

If you have a preference for the gender of the clinician, please specify below. Please note that we are more likely to connect you with a clinician sooner if you have no preference.

_____ Male   _____ Female   _____ No preference

Reasons or Concerns for Seeking Treatment

Symptoms of OCD (circle one):   YES / NO

Symptoms of Bipolar Disorder: YES / NO

Anger problems: YES / NO

Perfectionism: YES / NO

Stress and anxiety about academic or work performance: YES / NO

Interpersonal conflict: YES / NO

Symptoms of anxiety: YES / NO

Symptoms of depression: YES / NO

Parenting difficulties: YES / NO   If yes, age and gender of child: ________________________

Self-harming behaviors in the past 2 months?:   YES / NO

Self-harming behaviors in the past 6 months?:   YES / NO

If yes to self-harm, please specify: Burning/Cutting/Picking/Other: __________________

Suicidal thoughts? (Circle one):   YES / NO

If yes, how frequently? ____

Suicide attempts in the past 2 months: YES / NO

Suicide attempts in the past 6 months: YES / NO

If yes to suicide attempt, date of most recent attempt: __________________________

Hospitalizations in the past 2 months for mental health reasons: YES / NO

Hospitalizations in the past 6 months for mental health reasons: YES / NO

If yes, most recent dates of hospitalization: ____________________________________

History of trauma: YES / NO

If yes, please specify: Physical / Emotional / Verbal / Childhood / Sexual / Complex PTSD

History of psychosis: YES / NO

If yes, are you taking medication for this condition? YES / NO

Eating disorder concerns: YES / NO

If yes, please specify: Binging / Purging / Restricting / Other: ___________________

Alcohol or drug abuse: YES / NO

If yes, drug(s) of choice: ____

History of psychosis: YES / NO

If yes, are you regularly taking medications for this condition? YES / NO

Are you seeking services because of any legal involvement (e.g., court-mandated assessment or treatment, ICBC claims, custody dispute)? YES / NO

Other reasons or concerns for seeking treatment:

We appreciate your referral. Please fax this referral form to 604-630-7062. Once we receive the form, we will try our best to connect you/the client with one of our clinicians as soon as we can. Please note that due to overwhelming demand for services, there could be a wait time for clinicians depending on the type of service seeking and availability for appointments. In general, the more available a client is for appointments, the sooner we would be able to offer them services. Wait time for online/virtual appointments is relatively short. Wait time for clinicians with DBT experience is much longer. Please also note that we cannot guarantee service provision after receiving this referral. Thank you for your patience and understanding.