REFERRAL FORM

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DATE OF REFERRAL

__ __ / __ __ / __ __

Referred By: ______

Referral Source Fax: ______

Referral Source Email: ______

Referral Source Phone: ______

Family Physican: ______

Is the family physician in agreement with the referral?

- [ ] Yes
- [ ] No
- [ ] To be determined

PATIENT INFORMATION

Patient Name : ______

Phone Number: ______

Date of Birth : __ __ / __ __ / __ __

Full Address : ______

REASONS FOR REFERRAL:

- [ ] Seeking healthy lifestyle choices
- [ ] Improving health through meditation and yoga
- [ ] Major depressive disorder, current or past
- [ ] Anxiety
- [ ] Life stress, burnout, situational issues
- [ ] OTHER: ____________

ANY CONTRAINDICATIONS:

- [ ] Active suicidal ideation
- [ ] Acute psychosis, including hallucinations and delusions
- [ ] Abuse of alcohol or other substances (active or less than three months sobriety)
- [ ] Other issues limiting ability to participate in groups
- [ ] Recent traumatic event or ongoing reaction to trauma
- [ ] OTHER: ____________

WHICH PROGRAM ARE YOU REFERRING TO:

- [ ] Mindfulness-Based Stress Reduction
- [ ] Equine Facilitated Wellness - 6 Week Group
- [ ] Equine Facilitated Wellness - 12 Week Group
- [ ] Horse Healing Sessions

REFERRAL SOURCE AGREEMENT:

I agree to remain this person's healthcare provider in case of urgent physical or emotional issues during the course of this group. I agree to remain this person's provider (or to arrange alternate supports) in case of urgent physical or emotional issues during this group.

☐ **Yes** ☐ **No**

I understand that Dr. Brodhecker is not assuming transfer of care and is not my patient's psychiatrist during this program.

☐ **Yes** ☐ **No**