



MINDFUL MARE
Wellness

REFERRAL FORM

Dr. Shreyasi Brodhecker, MD, FRCP(C) Psychiatry, & colleagues

Phone: (780)399-2785

Fax: (780) 450-3644

mindfulmarewellness@gmail.com

DATE OF REFERRAL

/ /

Referred By:

Referral Source Fax:

Referral Source Email:

Referral Source Phone:

Family Physician:

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
- Interest in meditation and trauma-informed somatic practices
- Major depressive disorder, current or past
- Anxiety
- Life stress, burnout, situational issues
- Interest in self-care and stress reduction strategies
- 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 (note that chronic effects of trauma are not a contraindication)
- OTHER:

WHICH PROGRAM ARE YOU REFERRING TO:

- Sacred Ambrosia Equine Facilitated Therapy Group for Women Dealing with Infertility - 5 weeks
- Rooted in Devotion Womb Healing Program for Women Dealing with Infertility - 10 weeks
- 1:1 Equine Facilitated Therapy sessions - up to 12 sessions
- 1:1 Sessions for therapy and/or medication management

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