BounceBack® reclaim your health

bouncebackontario.ca | 1·866·345·0224

Canadian Mental Health Association Ontario

Ontario

Funded by the Government of Ontario

Please send referral information to your BounceBack team via fax: (905) 430-1768

PRIMARY CARE REFERRAL FORM

All fields must be filled out

BounceBack® is a free program for individuals aged 15 years and over experiencing mild to moderate depression, with or without anxiety. Community coaches provide telephone delivery of a brief, workbook-based, self-help program to improve mental health.

Referrer: ☐ Primary Care Practitioner (doctor/psychiatrist/nurse practitioner)

Patient name: _____ Gender: _____

Date of birth: _____ Phone: _____
(MM / DD / YYYY)

Easiest way to contact:

☐ Email ☐ Telephone

Address: _____ City: _____

Postal code: _____ Email: _____

MOA: Please apply patient address label or print legibly

Can we leave a voicemail message? ☐ Yes ☐ No

THIS SECTION MUST BE COMPLETED IN ORDER FOR THE REFERRAL TO BE PROCESSED

1. Please confirm that the individual:

True	False	
☐	☐	Is not severely depressed / PHQ-9 score from 0–21
☐	☐	Is not at risk to harm self or others
☐	☐	Is not significantly misusing alcohol or drugs
☐	☐	Does not have a personality disorder
☐	☐	Has not had manic episodes or psychosis within the past 6 months
☐	☐	Is capable of engaging with and concentrating on the materials

Please note that the primary healthcare practitioner always retains professional responsibility for the patient.

2. Please include the Patient Health Questionnaire (PHQ-9) score:

(see reverse for PHQ-9)

3. Is a language other than English preferred for telephone coaching? If yes, please identify language:

_____

4. Is the individual receiving medication for:

Depression? ☐ Yes ☐ No

Anxiety? ☐ Yes ☐ No

Primary Care Practitioner information:

Name: _____

Address: _____

Phone: _____ Fax: _____ CPSO# or CNO#: _____

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PHQ-9 - Please ask the patient the following:

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	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 television	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 a lot 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 problems, 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

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.