CBTm COGNITIVE BEHAVIOUR THERAPY WITH MINDFULNESS

CLIENT REFERRAL FORM
YOUTH CBTM CLASSES

Child Information

Full Name ______________________ Preferred Name ______________________

Date of Birth (MM/DD/YYYY) ____/____/________ PHIN ______________________

Email (For class purposes) ____

Parent/Guardian Information (1)

Full Name ______________________ Preferred Name ______________________

Relationship to Child ______________________ Phone Number ______________________

Email ______________________ Legal Guardian Foster Parent

Parent/Guardian Information (2)

Full Name ______________________ Preferred Name ______________________

Relationship to Child ______________________ Phone Number ______________________

Email ______________________ Legal Guardian Foster Parent

Child resides with: ______________________

Joint Court Ordered Custody?	Yes	No
Sole Custody?	Yes	No
Custody not yet established?	Yes	No
Current legal proceedings?	Yes	No

Referral Information

Referring Site ______________________

Referring Contact's Name ______________________

Referring Contact's Phone ______________________

Referring Contact's Fax ______________________

Referring Contact's Email ______________________

Primary Care Provider Information (optional)

Clinic/Office Name ______________________

Physician's Name ______________________

Physician's Phone ______________________

Physician's Fax ______________________

Physician's Email ______________________

*Refer back to: Primary Care Provider Referring Physician Both

*The patient/client can be referred back to your care via email or fax if requested on the referral form.

Contact us:
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University of Manitoba

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