



PATIENT REFERRAL FORM FOR VIRTUAL CBT_m CLASSES

PATIENT INFORMATION

First Name _____

Last Name _____

PHIN _____

Date of Birth _____

Phone Number _____

Email _____

Primary Care Provider _____

REFERRING SITE INFORMATION

Referring Site _____

Contact Name _____

Phone & Fax _____

Indicate stream: Facilitator-led (Zoom) OR Web-based (self-directed)

When CBT_m completed, where should we direct patient for follow-up?

Referring Site OR Primary Care

CBT_m Team Contact Info:

www.cbtm.ca

cbtmresearch@umanitoba.ca

Tel: (204)787-7729

Fax: (204)789-2819