



MINDFUL METHODOLOGY
PRESENCE. PURPOSE. PROGRESS.

Healthcare Provider Referral Form

Thank you for considering Mindful Methodology as a resource for your patient. Please complete this form and return via email to shalley@mindfulmethodology.ca. I will contact the patient within 24-48 hours to schedule their first appointment.

All information is kept strictly confidential in accordance with PHIPA.

REFERRING PROVIDER INFORMATION

Your Name: _____

Professional Title/Credentials: _____

(e.g., MD, NP, Social Worker, Case Manager)

Clinic/Hospital/Organization: _____

Email Address: _____

Phone Number: _____

Preferred Contact Method: Email Phone Either

PATIENT INFORMATION

Patient Name: _____

Patient Email: _____

Patient Phone Number: _____

Patient Date of Birth: _____

Preferred Contact Method: Email Phone Text Message

Best Time to Reach Patient: _____

REFERRAL DETAILS

Primary Reason for Referral (check all that apply):

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> ADHD/Neurodivergence |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Addiction/Substance Use |
| <input type="checkbox"/> Trauma/PTSD | <input type="checkbox"/> Self-Harm |

- Grief & Loss
- Life Transitions
- Relationship/Family Issues
- Suicidal Ideation (stabilized)
- Post-Crisis Follow-Up
- Other: _____

Brief Clinical Summary (Optional - no detailed medical information needed):

Urgency Level: Routine (1-2 weeks) Moderate (within 1 week) Urgent (ASAP)

Is the patient currently (check all that apply):

- On waitlist for psychiatry
- Currently taking psychiatric medication
- Currently working with other mental health providers
- Recent discharge from hospital/crisis services
- None of the above

ADDITIONAL INFORMATION

Does the patient have extended health benefits/insurance? Yes No Unknown

Any barriers to virtual therapy? (e.g., lack of private space, internet issues, language):

Anything else I should know?

COLLABORATIVE CARE

Would you like progress updates? (with patient consent)

- Yes, with patient consent
- No updates needed
- Only for safety concerns

If yes, preferred frequency: After initial assessment Monthly As needed Discharge only

CONSENT STATEMENT



By submitting this referral, I confirm that:


- I have discussed this referral with the patient and they are aware they will be contacted
- The patient has consented to this referral

Referring Provider Signature: _____

Date: _____

MINDFUL METHODOLOGY

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 www.mindfulmethodology.ca | Virtual therapy serving Ontario