The Art of Living Mindfully

Mindfulness Meditation Referral Form

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BCALM.ca

PLEASE COMPLETE **ALL** INFORMATION BOXES **INCLUDING EMAIL ADDRESS**. INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED.

Date of Referral:		
Client Name:		Phone:
Address:		***Client email address***
DOB:	Age: 20+ y/o	PHN:
Referred by: Clinic: Phone: Fax:		Family Physician: Phone: Fax:

Please provide brief history and current stressors ☐ HISTORY ATTACHED

Diagnosis and ICD9 code:

Please confirm whether your patient has received at least 2 doses of a Health Canada approved COVID-19 vaccine ☐ **yes** ☐ **no**

CONDITIONS: Please indicate all that apply:

☐ Depression ☐ Anxiety ☐ Insomnia ☐ Addiction

☐ PTSD NO ACTIVE SYMPTOMS ☐ Personality Disorder ☐ Chronic Pain ☐ Acute Stress Situation

Other Conditions:

MEDICATIONS: ☐ **NO MEDICATIONS** ☐ LIST ATTACHED

Please confirm this patient is appropriate for group based learning: (In the event of unclear group suitability additional information may be requested)

☐ **DOES NOT** have a**ctive** substance use <6 months ☐ **DOES NOT** have a disorder that might interfere with group learning (eg PD)
☐ **IS NOT** cognitively impaired ☐ **HAS NOT** had **active** PTSD sx for > 6 months (nightmares, flashbacks, dissociation)
☐ **DOES NOT** have criminal/legal issues pending ☐ **DOES NOT** have **active** psychosis ☐ **IS NOT** at-risk to harm self or others

☐ **PATIENT IS AWARE OF AND APPROVES THIS REFERRAL**
☐ **UNDERSTANDS THIS 8 WEEK COMMITMENT; 90-120 MIN CLASS AND 10-30 MIN HOME PRACTICE/DAY**

2026-03 WS01

We request that the referring clinician be available to the client for therapeutic support if the need arises. This program **cannot** provide emergency/additional sessions or support.