The Art of Living Mindfully

Mindfulness Meditation for MCI

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Mild Cognitive Impairment Group (ONLY)

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:	PHN:
Referred by: Clinic: Phone: Fax:	Family Physician: Phone: Fax:
Support person (if there is one) who will be participating with and supporting client	
Support Name:	Phone:
Relationship to Client:	*__Support__ email address*
ICD9 of Support Person	
DOB:	PHN:
Referred by: Clinic: Phone: Fax:	Family Physician: Phone: Fax:

Please provide brief history for your client

Client Diagnosis and ICD9 code:	**Client MOCA Score:** (Recommended above 18)

Please indicate any other **conditions** that apply:

☐ Depression ☐ Anxiety ☐ Insomnia ☐ Chronic Pain

Other Conditions:

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

Please confirm this client is appropriate for group based learning:

☐ **HAS FULL SELF-AWARENESS** ☐ **IS INDEPENDENT in ADL's AND SELF CARE**
☐ **IS ABLE to commit to an 8 week course: 90-120 minutes a week PLUS 10-30 minutes a day to home practice**
☐ **HAS THE ABILITY TO ACCESS ZOOM LINKS, EMAILS, ETC INDEPENDENTLY *OR* HAS SOMEONE READILY ON HAND TO ASSIST**
☐ **PATIENT AND SUPPORT ARE AWARE OF AND APPROVE THIS REFERRAL**

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.