



**Creating community-based self-help strategies to improve mental health for all**

For adults (at least 19 years of age) experiencing mild to moderate depression (PHQ-9 range = 5 to 21), with or without anxiety, community coaches provide telephone delivery of a brief, workbook-based, self-help program to improve mental health.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(MM/DD/YYYY)

Messages OK?  Yes  No

Address: \_\_\_\_\_  
\_\_\_\_\_

MOA: Please apply patient address label or print legibly

<p><b>1. Please confirm that the patient:</b></p> <p><input type="checkbox"/> Is <u>not</u> severely depressed / PHQ-9 score from 5 to 21</p> <p><input type="checkbox"/> Is <u>not</u> at risk to harm self or others</p> <p><input type="checkbox"/> Is <u>not</u> significantly misusing alcohol or drugs</p> <p><input type="checkbox"/> Does <u>not</u> have a personality disorder</p> <p><input type="checkbox"/> Has <u>not</u> had manic episodes or psychosis within the past 6 months</p> <p><input type="checkbox"/> Is capable of engaging with and concentrating on the materials</p>		<p><b>Please note that the referring primary health care practitioner always retains professional responsibility for the patient.</b></p>
<p><b>2. If available, please include the patient's PHQ-9 score:</b></p> <p>PHQ-9 score: _____</p>	<p><b>4. Is the patient receiving medication for:</b></p> <p>Depression? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p><b>3. Please indicate the patient's preferred language for telephone coaching:</b></p> <p><input type="checkbox"/> English <input type="checkbox"/> French</p> <p><input type="checkbox"/> Cantonese <input type="checkbox"/> Punjabi</p>	<p><b>5. Was the patient given a copy of (or a link to) the Bounce Back DVD?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>6. Is this referral being made as part of the 'Rx for Health' Program?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

**Referring Primary Care Practitioner Name and Contact Information**

\_\_\_\_\_

Please email this completed form directly to:  
bounceback@cmha.bc.ca

or call the following toll-free phone number to contact your local Bounce Back team:  
1-866-639-0522

or use the appropriate regional fax number below: