SHREYASI BRODHECKER

REFERRAL FORM

Dr. Shreyasi Brodhecker, MD, FRCP(C) Psychiatry, & colleagues
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DATE OF REFERRAL

☐☐ / ☐☐ / ☐☐

Referred By: _____ **Referral Source Fax:** _____

Referral Source Email: _____ **Referral Source Phone:** _____

Family Physican: _____

Is the family physician in agreement with the referral?

- ☐ **Yes**
- ☐ **No**
- ☐ **To be determined**

PATIENT INFORMATION

Patient Name : _____ **Phone Number:** _____

Date of Birth : ☐☐ / ☐☐ / ☐☐

Full Address : _____

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REASONS FOR REFERRAL:

- [ ] Seeking emotional support while trying to conceive
- [ ] Interest in meditation and trauma-informed somatic practices
- [ ] Major depressive disorder, current or past
- [ ] Anxiety
- [ ] Life stress, burnout, situational issues
- [ ] Interest in self-care and lifestyle changes to support emotional well-being
- [ ] History of chronic or remote trauma
- [ ] OTHER:

ANY CONTRAINDICATIONS:

- [ ] Active suicidal ideation
- [ ] Acute psychosis, including hallucinations and delusions
- [ ] Abuse of alcohol or other substances (active or less than three months sobriety)
- [ ] Other issues limiting ability to participate in groups
- [ ] Recent traumatic event (note that chronic effects of trauma are not a contraindication)
- [ ] OTHER:

WHICH PROGRAM ARE YOU REFERRING TO:

- [ ] Sacred Ambrosia Equine Facilitated Therapy Group for Women Dealing with Infertility - 5 weeks
- [ ] Rooted in Devotion Womb Healing Program for Women Dealing with Infertility - 10 weeks
- [ ] 1:1 Sessions for therapy and/or medication management

REFERRAL SOURCE AGREEMENT:

I agree to remain this person's healthcare provider in case of urgent physical or emotional issues during the course of this group. I agree to remain this person's provider (or to arrange alternate supports) in case of urgent physical or emotional issues during this group.

- [ ] **Yes** - [ ] **No**

I understand that Dr. Brodhecker is not assuming transfer of care and is not my patient's psychiatrist during this program.

- [ ] **Yes** - [ ] **No**