BounceBack®
reclaim your health

www.bouncebackontario.ca

phone: 905-222-0823 • toll free: 1-866-345-0224

Please send referral information to your Bounce Back team via Fax: 905-841-3007

ALL FIELDS MUST BE FILLED OUT

Bounce Back® is a free program for individuals aged 15 years and over experiencing mild to moderate depression, with or without anxiety. Community coaches provide telephone delivery of a brief, workbook-based, self-help program to improve mental health.

Referrer: ❑ Primary Care Practitioner (doctor/psychiatrist/nurse practitioner) ❑ Self or other referrer

Patient name: ______________________ Gender: ______________

Date of birth: ____________ (MM/DD/YYYY) Phone: ______________________

Easiest way to contact: ❑ Email ❑ Voicemail

Address: ______________________ City: ______________

Can we leave a voicemail message? ❑ Yes ❑ No

Postal code: ____________ Email: ______________________

MOA: Please apply patient address label or print legibly

Is the patient a Green Shield Plan member? ❑ Yes ❑ No Employer name: ______________________

1. Please confirm that the individual:

- ❑ Is not severely depressed / PHQ-9 score from 0–21
- ❑ Is not at risk to harm self or others
- ❑ Is not significantly misusing alcohol or drugs
- ❑ Does not have a personality disorder
- ❑ Has not had manic episodes or psychosis within the past 6 months
- ❑ Is capable of engaging with and concentrating on the materials

Please note that the primary health care practitioner always retains professional responsibility for the patient.

2. Please include the PHQ-9 score:

patient health questionnaire = PHQ-9

(please see reverse for PHQ-9)

3. Is a language other than English required for telephone coaching? If yes, please identify language:

____

4. Is the individual receiving medication for:

Depression? ❑ Yes ❑ No

Anxiety? ❑ Yes ❑ No

Primary Care Practitioner information:

Doctor's name: ______________________

Address: ______________________

____

Phone: ______________ Fax: ______________

CPSO# (for doctors offices only): ______________

OFFICE USE ONLY:

1st Contact Date/Time: ______________

2nd Contact Date/Time: ______________

3rd Contact Date/Time: ______________

Coach: ______________

S1Booked: ______________

DB-CaseID: ______________

CRMS#: ______________

BB Practitioner Referral Form (2017-06-01)

I give the Canadian Mental Health Association permission to correspond with my Primary Care Practitioner

❑ Yes ❑ No

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Canadian Mental Health Association Ontario

Ontario

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

for office coding: _______ + _______ + _______ + _______

= total score: _______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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BB PHQ screen (2015-08-31)