BounceBack® reclaim your health

www.bouncebackontario.ca

Canadian Mental Health Association Ontario

Ontario

Toll free: 1-866-345-0224

Please send referral information to your Bounce Back team via Fax: 905-241-5491

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: _____

Postal code: _____ Email: _____

MOA: Please apply patient address label or print legibly

Can we leave a voicemail message? ❑ Yes ❑ No

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#: _____

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

❑ Yes ❑ No

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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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