



**DEPRESSION TREATMENT GROUP**  
**REFERRAL FORM**

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

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

Phone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

**RHEUMATOLOGY DIAGNOSIS:**

- Inflammatory Arthritis
- Fibromyalgia
- Osteoarthritis
- Scleroderma
- Lupus
- Other: \_\_\_\_\_

**ADMISSION CRITERIA CHECKLIST**

(please check each box to ensure that all criteria are met)

**General Criteria:**

- Patient must be able to attend 8-10 weekly sessions from 4:00 PM – 5:30 PM on Mondays
- Patient must be open to learn self-management strategies for managing their depression
- Patients must be able to work collaboratively with a group setting
- Patients must be able to read English at a grade 8 level.

**Diagnostic Criteria (Rheumatology):**

- Patient must have been diagnosed with a rheumatological condition
- The diagnosis has been confirmed by a Rheumatologist (not necessary for OA)
- A copy of most recent rheumatology consultation note is included. (not necessary for OA)

**Diagnostic Criteria (Mood):**

- Patient meets diagnostic criteria for a major depressive episode, major depressive disorder or dysthymia
- If receiving anti-depressant treatment, medications should be stabilized during the assessment and treatment process. (ie. no expected changes in dose or type of medication).
- Patient does not exhibit manic episodes or psychotic features.
- Patient is not at imminent risk for suicide (i.e. does not require immediate, emergency care)

**Physician Name (print):** \_\_\_\_\_ **Date :** \_\_\_\_\_

**Date Received:** \_\_\_\_\_ **Assessed:** \_\_\_\_\_ **Admitted:** \_\_\_\_\_