DR. PAULINE LYSAK

PSYCHIATRIST B.Med, M.D., FRCP(C)

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PSYCHO-EDUCATION / SKILLS-BASED GROUP TRAINING:

TOOLS FOR TRAUMA

Fax completed referral form to: (250) 483-7643

Patient Info

NAME	
ADDRESS	DOB (D/M/Y) **AGE 18+**
	PHN
	TEL
EMAIL (REQUIRED)	

Referring Clinician (MRP)

NAME	MSP
ADDRESS / TEL / FAX	
EMAIL	

Patients have a trauma-focused, one-time consultation with Dr. Lysak first to ensure the group is a good fit. She will provide diagnostic and treatment recommendations, but cannot offer individual treatment.

SEEN PSYCHIATRY BEFORE? ☐ ER / PES ☐ Inpatient ☐ Followed as outpatient at _____ ☐ One-time consult(s)	PHQ-9 (<19)
PSYCHIATRIC DIAGNOSIS	

MEDICATIONS ☐ None	PAST PSYCHIATRIC MEDICATIONS
	PAST MEDICAL HISTORY

☐ **IMPACTED BY TRAUMA AND/OR CHILDHOOD EMOTIONAL NEGLECT** (PTSD Diagnosis not required)

☐ **PATIENT IS APPROPRIATE FOR GROUP LEARNING**

- Is not at risk to harm self or others
- Is not cognitively impaired
- Does not have active psychosis or mania
- Does not have symptoms of personality disorder, substance use, or other disorder severe enough to interfere with group-based learning

☐ **PATIENT APPROVES THIS REFERRAL**

- Is aware of the commitment, fees, technology requirements to participate via Zoom

☐ **I (OR MY CLINIC) WILL PROVIDE ONGOING PRIMARY CARE AND THERAPEUTIC SUPPORT IF THE NEED ARISES**

- Dr. Lysak cannot provide emergency or additional sessions or other individual support

DATE (D/M/Y)	SIGNATURE

Please attach copies of previous psychiatric consultations, recent lab work, and other relevant documentation.