

Unit 301B 1230 91 Street SW, Edmonton, T6X 0P2 T: 587-635-5291 F: 780-250-2401

MEDICAL CBT PROGRAM REFERRAL Dr. Prasanna Yelnadu

Last Name	
First Name	
Date of Birth	
Address	
PHN	
Home Phone	Cellphone
E-mail (required)	
Family Physician	

Referral from an MD required

REASON FOR REFERRAL

Referrals need to have at least one of the	□ Coping with Medical Illneses
following:	
□ Anxiety	☐ Depression without psychosis or
	suicidal tendencies
□ Depression	□ Acute Stress
□ Insomnia	☐ Substance Abuse Disorder
□ Phobia	☐ Lifestyle Medicine
□ Acute Stress	☐ Healthy eating/ Behaviour Change
☐ Any other psychiatric illness	☐ ITLC (Intensive Therapeutic Lifestyle
	Change)
Please include any relevant Medical History/	□ ADHD
Allergies/ Medications:	□ Chronic Pain
	□ PTSD
	☐ Illness Anxiety Disorder (Recent
	Diagnosis of Myocardial Infarction,
	Diabetes, Hypertension, Cancer or any
	debilitating Illness)

PLEASE FAX REFERRAL TO: SALUTOGENESIS CLINC/ DR. PRASANNA YELNADU FAX #: 780-250-2401