



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 following:	<input type="checkbox"/> Coping with Medical Illnesses
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression without psychosis or suicidal tendencies
<input type="checkbox"/> Depression	<input type="checkbox"/> Acute Stress
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Substance Use Disorder
<input type="checkbox"/> Phobia	<input type="checkbox"/> Lifestyle Medicine
<input type="checkbox"/> Acute Stress	<input type="checkbox"/> Healthy eating/ Behaviour Change
<input type="checkbox"/> Any other psychiatric illness	<input type="checkbox"/> ITLC (Intensive Therapeutic Lifestyle Change)
<i>Please include any relevant Medical History/ Allergies/ Medications:</i>	<input type="checkbox"/> ADHD
	<input type="checkbox"/> Chronic Pain
	<input type="checkbox"/> PTSD
	<input type="checkbox"/> Illness Anxiety Disorder (Recent Diagnosis of Myocardial Infarction, Diabetes, Hypertension, Cancer or any debilitating Illness)

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