Mindfulness Based Stress Reduction (MBSR) Virtual Program

Dr. Jillian MacDonald, MD, CCFP
Email: drjillianmacdonald@protonmail.com
Fax: (226) 213-7148

Patient Information:	**Referring Physician Information:**
Name:	Physician Name:
Date of Birth:	OHIP Billing Number:
Health card number incl version code:	Fax:
Address:	Phone:
Phone:	Family Physician:
Email:	

Past Medical History **must have chronic pain diagnosis for eligibility (please list chronic pain/mental health/other pertinent):

Criteria for eligibility (please circle):

1. Does this patient have untreated trauma/PTSD? (ie. have not had counselling or therapy)	Yes	No
2. Does this patient have an active substance abuse disorder? (should be stable 1 year)	Yes	No
3. Does this patient have severe anxiety or depression?	Yes	No
4. Does this patient have active suicidal thoughts or attempted suicide in the last 6 months?	Yes	No
5. Does this patient have active psychosis or mania?	Yes	No
6. Does this person have a dissociative disorder or are they known to dissociate?	Yes	No