CBT Alberta — Referral Form (12-week CBT Email Program). Fax to 5876892266

CBT Alberta – Safety & Scope Notice
This program **does not** accept patients with **acute safety concerns** or **active suicidality**, **psychosis**, **mania**, or other conditions requiring urgent/in-person psychiatric assessment. If urgent risk is present, refer to emergency services / local crisis supports / 911.

REFERRING CLINICIAN

Date of Referral (YYYY-MM-DD)	
Name*	
PRAC ID / CPSA #*	
Clinic Name*	
Clinic Phone	
Clinic Fax Number*	
Clinic Address	
Signature*	

Please confirm	Check
I agree to see this patient in person if clinical issues arise.*	☐
I confirm this patient has no active suicidality, psychosis, or mania.*	☐
I confirm this referral is appropriate for a structured CBT email program (12 weeks).*	☐

PATIENT INFORMATION

Patient Name*	
Date of Birth (YYYY-MM-DD)*	
Gender	
AHC Number / ULI*	
Cell Phone*	
Email Address	
Address*	

CLINICAL NOTES (BRIEF)

PROGRAM SELECTION (SELECT ONE)

Sel.	Course	Focus / Skills
☐	**Anxiety email CBT**	Cognitive restructuring, exposure therapy, relaxation
☐	**Depression email CBT**	Behavioral activation, thought challenging, mood tracking
☐	**ADHD email Behavioral Modification**	Time management, organization, focus strategies