



IMPORTANT NOTE: All fields must be completed to process the referral.

The participant will be contacted within 5–10 business days of receiving the referral form.

BounceBack[®] is a free program for individuals aged 13 years and over experiencing anxiety and/or mild to moderate depression (PHQ-9 score is 23 or lower). Community coaches provide telephone delivery of a brief, workbook-based, self-help program to improve mental health.

Participant information

Name: _____ Gender: _____

Date of birth: _____ Phone: _____ Home Mobile
(MM/DD/YYYY)

Address: _____ City: _____

Postal code: _____ Email: _____

Best ways to contact participant: SMS Email Phone

Can a confidential message be left at this number? Yes No

Primary Care Provider

Name of clinic/school: _____

Referrer name: _____

Physician Nurse Practitioner
 Psychiatrist Psychologist
 School Counsellor
 Registered Social Worker
 Registered Clinical Counsellor

Address: _____

Phone: _____

Fax: _____

Email: _____

Please note that the referring care practitioner always retains clinical responsibility, which includes assessing suicide risk and follow-up/ treatment and informing the referred individual if ineligible for the program.

Parent/guardian contact information (for adolescents age 13–18 only)

Name: _____

Relationship: _____

Email: _____ Phone: _____

Is this referral confidential from parent/guardian Yes No

1. Please confirm that the participant:

- 13 years of age or older, currently living in BC
- Primary care provider listed accepts clinical responsibility for the participant during the program (physician, nurse practitioner, psychiatrist, school counsellor, psychologist, registered social worker and registered clinical counsellor)
- Is not significantly depressed / PHQ-9 score is 23 or lower
- Is not at risk to harming self or others
- Is not significantly misusing alcohol or drugs to the extent that would impact engagement in CBT treatment
- Is not diagnosed with a personality disorder
- Has not had a manic episode or psychosis in last 6 months
- Is capable of engaging with and concentrating on workbook materials
- Has not self-harmed more than 3 times in the past month

2. Participant's PHQ-9 score:

PHQ-9 score: _____

3. Is the participant receiving medication for:

- Depression Anxiety

4. Please indicate the participant's preferred language for telephone coaching:

- English French Mandarin
- Cantonese Punjabi

Please transmit referral information to your local Bounce Back[®] team:

Regional Fax Numbers • Okanagan: 1-250-374-1293 • Northern Health: 1-250-562-3569 • Vancouver Island: 1-877-748-2606 / 604-398-4695
• Fraser Health and Vancouver Coastal: 1-604-872-5934

Please include the PHQ-9 total score on the first page. You do not need to submit this page with your referral. To determine the PHQ-9 please ask the participant the following:

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling down, depressed, or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Trouble falling or staying asleep, or sleeping too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Little interest or pleasure in doing things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Moving or speaking so slowly that others notice? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
_____ + _____ + _____ + _____ = total score: _____				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Not difficult at all Somewhat difficult Very difficult Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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