



## Food as Medicine (FAM) - Referral Form

### Referring physician information

Name:

---

MSP Number:

---

Office Address:

---

Office Phone:

---

Office Fax:

---

### Patient information

First Name:

---

Last Name:

---

MSP:

---

Date of Birth:

---

Assigned sex at birth:

Gender:

Pronouns:

---

Phone:

---

Email:

---

Address:

---

### Medical information

Psychiatric Diagnosis:

---

Medical Diagnosis:

---

**Please ensure that you can answer “yes” to the following questions prior to referring your patient to the group.**

Is your patient (or family member) able to cook/prepare their own meals? **Yes**  **No**

**Diagnoses accepted:** major depressive disorder, bipolar depression, persistent depressive disorder and fibromyalgia.

Continue to next page for exclusion criteria.



**Exclusion criteria:**

Patients who are in full remission (asymptomatic) or who are currently manic or hypomanic do not qualify for the group treatment.

Patients with active eating disorders, active alcohol/substance use disorders, autism spectrum disorders, severe cognitive impairment are not appropriate referrals for this group treatment.

*This group does not manage psychiatric medications. If your patient is actively suicidal or has symptoms of psychosis they will need to be psychiatrically stabilized prior to referral to the group.*

**Please check the appropriate boxes in the questions below:**

*Which group are you referring your patient to?*

Mood and pain GMV  Mood Disorder GMV

*Has your patient had a psychiatric consultation? If yes, please send a copy of the consultation.*

Yes  No

*Has your patient had a consultation for a pain disorder? If yes, please send a copy of the consultation.*

Yes  No

*Has your patient had lab tests in the last 6 months? If yes, please send a copy of the lab results.*

Yes  No

**Eligibility Requirements**

To be eligible for the program, all patients must complete the following steps prior to submitting their referral.

1. Watch the Introductory Video  
Watch the [introductory video](#) to understand the program's goals, structure, and expectations.
2. Complete the Required Questionnaire Below

**PLEASE FAX COMPLETED FORM AND ANY ATTACHMENTS  
TO MDABC at 1-866-821-5992**



**This questionnaire is to be completed by the patient. Please include the completed questionnaire, along with the referral form and any other attachments, and fax it to MDABC at 1-866-821-5992. *Please note, if we do not receive the full referral, we will not process it and will send it back to be complete.* Thank you.**

1. This group medical program lasts for 8 consecutive weeks, followed by a group follow-up session 4-8 weeks after the final session. Each weekly appointment is 90 minutes long. Participation requires a full 8-week commitment, including attending all sessions, completing blood work, and following the recommended treatment protocol to the best of your ability. Do you agree to these requirements?

I agree  I do not agree

2. Are you willing to implement any lifestyle adjustments that may be recommended by the Doctor? For example, anti-inflammatory modifications to nutrition, sleep optimization, stress management, and optional supplements will be recommended. Budgetary differences will always be respected and taken into consideration.

Yes  No

3. I certify that I have watched the [introductory video](#) and understood the requirements of the group.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you for completing this questionnaire.*