

# STEPS Group Therapy – External Referral Request Letter

Phone: 250-312-2127 Fax: 236-220-2036

stepshealth.ca

**Date:** Feb 17, 2026

**To:** Community Physicians & Nurse Practitioners

**Re:** Referral Pathway for STEPS Virtual Group Therapy Programs

Dear Colleagues,

STEPS is currently accepting referrals for our **virtual group therapy programs** delivered via Zoom. These groups are suitable for **adult (19+) patients** who would benefit from structured skill-building, psychoeducation and therapist facilitated sessions.

We are asking clinics to use the attached materials when referring patients to our groups. Please ensure that **all required forms are completed and faxed together**, as incomplete referrals cannot be processed and will be returned.

Detailed descriptions of all groups can be found in the attached information package. Sessions run regularly, and participants are assigned to the next available group. **We are also pleased to share that our DBT group is now open to external patients.**

## Required Referral Documents

Please fax the following **together**:

- 1. STEPS Group Therapy Referral Form**
  - Completed by Family Physician or Nurse Practitioner
  - Includes confirmation of patient readiness and exclusion criteria
- 2. STEPS Confidentiality and Consent to Group Service Form**
  - Must be completed and signed by the patient
  - Patients must understand and agree to group rules, confidentiality, and virtual participation requirements

Once all forms are complete, please fax to **236-220-2036**

Our Community Health Worker will contact the patient directly to schedule them into the next available group.

If you have questions, please reach out to:

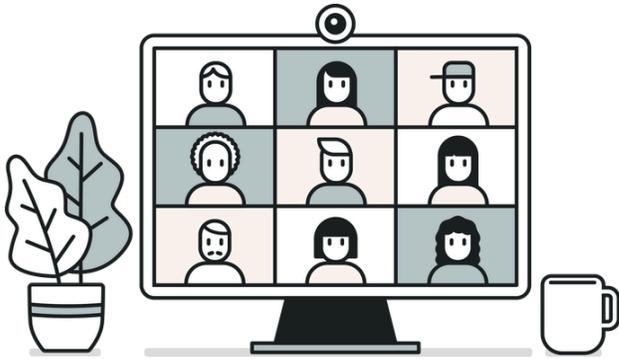
**Madison Pilbeam** - Community Health Worker

Email: [mpilbeam@stepshealth.ca](mailto:mpilbeam@stepshealth.ca)

# STEPS VIRTUAL SPRING SESSIONS

## Group Therapy Sessions (via Zoom)

with Psychiatrist Dr Kristina Birkholz  
and Registered Social Worker Angela Owen or Registered Nurse Katie McPherson



### Befriending Your Nervous System

Befriending Your Nervous System group offers **6 sessions (90 minutes per weekly session)** based in Polyvagal Theory, a framework for understanding your nervous system. Participants will learn skills to shift more naturally between nervous system states, feel more regulated and spend less time “stuck” in states such as fight, flight or freeze. There will be opportunities to listen, share, ask questions and use worksheets for reflection and practice.

### Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy group offers **8 sessions (90 minutes per weekly session)** designed to increase awareness of thoughts, behaviors, emotions, and physical sensations and how they are connected. Participants will learn new skills to shift unhelpful thought patterns and beliefs, change unhelpful behaviours and shift emotional states. There will be opportunities to listen, share, ask questions and use worksheets for reflection and practice.

### Effective Communication

Effective Communication group offers **6 sessions (90 minutes per weekly session)** designed to increase awareness of one’s communication styles and assertiveness skills. This group includes some CBT and DBT concepts. Participants will learn new skills to shift unhelpful communication styles and build more effective skills. Each session will cover a component of effective communication with an emphasis on assertiveness. There will be opportunities to listen, share, ask questions and use worksheets for reflection and practice.

### Coping with Chronic Conditions

This **9-week group (90 minutes per weekly session)** is designed to help people develop coping skills and improve quality of life related to living with a chronic condition. Participants will learn new skills related to a variety of topics such as emotions, unhelpful thoughts, and communicating in the context of a chronic condition. Group members will have the opportunity to support each other in the group process.

**Who is eligible to register for Coping with Chronic Conditions?** Patients who are experiencing distress as a result of chronic medical conditions such as long covid, fibromyalgia, chronic fatigue syndrome, headaches, chronic pain, post concussion syndrome, postural orthostatic tachycardia syndrome (POTS), diabetes, and other significant illnesses.

### Dialectical Behavioural Therapy (DBT)

Dialectical Behavioural Therapy (DBT) group offers **12 sessions (120 minutes per weekly session)**. DBT is an evidence-based and structured therapeutic approach aimed at developing skills to help manage intense emotions, cope with challenging life situations, and improve relationships. DBT focuses on finding a balance between acceptance of oneself and the need for change. There are 4 core modules of skills in DBT: mindfulness skills, distress tolerance skills, emotional regulation skills, and interpersonal effectiveness skills. The workbook for this group contains DBT skills worksheets that support weekly skill practice. A portion of each group will include a review of skills practice to help strengthen skill development.

**Referral required, please contact your family physician or nurse practitioner's office**



# STEPS Group Therapy Referral Form

Date: \_\_\_\_\_

*To be completed by Family Physician or Nurse Practitioner for Group Therapy Referral*

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Personal Health Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## 1. Informed Consent

a) Has the patient completed the informed consent forms?

Yes

No

b) Does the patient have any questions that could not be answered about the informed consent?

Yes

No

If yes to 1. b), please provide the patient with the following email address: [mpilbeam@stepshealth.ca](mailto:mpilbeam@stepshealth.ca) to reach our Community Health Worker Madison

**Please ensure completed informed consent forms are attached to this referral.**

**Referrals submitted without the consent forms will not be processed.**

## 2. Group Selection and Goals

a) What group(s) is the patient wishing to attend?

- |  |   |
|--|---|
| <input type="checkbox"/> Befriending your Nervous System       | <input type="checkbox"/> Coping with Chronic Conditions |
| <input type="checkbox"/> Cognitive Behavioural Therapy (CBT)   | <input type="checkbox"/> Effective Communication        |
| <input type="checkbox"/> Dialectical Behavioural Therapy (DBT) |   |

b) What goal(s) is the patient hoping to achieve from attending group(s)?

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# STEPS Group Therapy Referral Form

Date: \_\_\_\_\_

### 3. Understanding & Readiness for Group Participation

- a) Has the patient completed the informed consent forms?  Yes  No
- b) Has the patient checked the dates for upcoming groups and confirmed no scheduling conflicts?  Yes  No
- c) Is the patient able to use Zoom and remain on video to attend (e.g., has own device with working audio and video)?  Yes  No
- d) Does the patient have a private space for group attendance (e.g., parked car, private office, or bedroom)?  Yes  No
- e) Does the patient understand the importance of abstaining from eating and substance use during group time?  Yes  No
- f) Is the patient able to participate in the group in a respectful and appropriate manner?  Yes  No

### 4. Exclusion Criteria Review

Please confirm you have reviewed the patient's medical record for the following exclusion criteria, Check if any of the following apply:

- The patient answered "no" to any of the questions related to readiness for group participation
- Experiencing acute crisis or psychiatric emergency (e.g., active suicidality, psychosis, or mania)
- Unable to engage in primary activities of the group due to logistical, intellectual, psychological, or interpersonal reasons (e.g., severe cognitive impairment, emotional dysregulation, intellectual disability)
- Unable to attend group safely (e.g., agitated/aggressive behavior, unable to refrain from sharing triggering material)
- Unwilling to voluntarily participate in a group setting

**If any boxes in section 4 above are checked, please DO NOT refer the patient to group therapy.**

Once this form is complete and the patient meets criteria, please fax to STEPS at 236-220-2036

Referring Provider Name: \_\_\_\_\_

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

Clinic Name, Phone & Fax: \_\_\_\_\_

## **STEPS Confidentiality and Consent to Group Service**

You are registering for a STEPS virtual group therapy program. This is a voluntary service. Information regarding your involvement with STEPS is confidential and protected.

NOTE: There are exceptions to confidentiality where it would be necessary to report specific information. This could include the following situations:

1. If we suspect someone is being neglected or abused
2. If we suspect someone may do serious physical harm to themselves or to others
3. If our staff and/or our records are subpoenaed by the court, we are obligated to testify

Health related information including group participation is kept in an electronic medical record called Med Access. Access to this record is restricted to STEPS professionals involved in your care.

You are consenting to receive healthcare through electronic communication technologies, including video conferencing and/or phone calls. While virtual care offers some conveniences, it also involves potential limitations, such as disruptions due to technology failure. All efforts will be made to ensure your privacy and the security of your health information in accordance with applicable privacy laws and professional standards. You have the right to ask questions, decline virtual care, or withdraw your consent at any time.

The program will occur over the Zoom for Healthcare video conferencing service. According to Zoom's privacy policy:

"Zoom takes your privacy extremely seriously and only collects the data from individuals using the Zoom platform required to provide the service and ensure it is delivered effectively. Zoom does not monitor your meetings or its contents. Zoom complies with all applicable privacy laws, rules, and regulations in the jurisdictions in which it operates, including the GDPR and the CCPA."

Confidentiality is taken very seriously in our groups. All group members are expected to maintain the confidentiality of the group. Any recording of the group meeting video, audio or chat is not permitted and any options to do this within the Zoom platform have been disabled.

The following group rules apply to the group you are registering for:

### **1. Confidentiality**

- Ensure your screen name does not contain your last name
- Group membership and what is said in group stays in group
- Ensure that you are in a private space and that other people cannot see or hear the group meeting. Please keep your video on for the duration of the group.
- Limits to confidentiality are around safety concerns to self or others, or if a child is at risk

### **2. Please arrive on time, stay for the duration of the group and keep**

regular attendance. Group members must reside in BC and be physically located in BC while attending virtual groups.

3. Mutual respect

- Demonstrate active listening
- Present yourself as you would if this group were in person
- Limit distractions around you and please do not multitask with other activities or travel to other appointments during group time

4. Use "I" statements when communicating. Limit "you" statements and advice giving.

5. Please avoid dialogue that may be triggering to others in the group.

6. Please do not attend group under the influence of recreational substances. Please do not use substances during group time, including cigarettes or vaping.

7. Please do not eat in group. Non-alcoholic beverages are allowed.

8. Have your phone close by in case we need to contact you individually.

9. Facilitators are available briefly after group, if you need additional support with group content.

10. Work actively and to the best of your ability in group.

I, \_\_\_\_\_ (print name) understand the limits of confidentiality as outlined above. I have been given information regarding group therapy and provide my consent to this service.

\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Patient Signature**

**Date (dd/mm/yyyy)**

If the patient has given verbal consent only, complete the following:

- Confidentiality was discussed with the patient and the patient provided verbal consent to group therapy service

\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Staff signature**

**Date (dd/mm/yyyy)**

\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Staff who obtained consent (print name)**

**Date (dd/mm/yyyy)**