

SATA Centre for Conscious Living

Surrender, Allow, Trust, Accept

<https://www.satacentre.com/>

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Living Consciously with Terminal Illness Referring Information for Providers

We offer **MSP-funded, evidence-based, mindfulness-centered group support programs** for patients with **terminal or life-limiting illnesses** (e.g., metastatic cancer, end-stage heart, lung, kidney disease, ALS). There is **no cost to patients**.

These programs help patients:

- Reduce stress, anxiety, and depression
- Stay present and connected with their bodies and emotions
- Explore meaning, purpose, and spirituality
- Access practical knowledge to plan and navigate their journey

Programs Options:

1. **A New Beginning:** 4–8-week supportive therapy groups (weekly Zoom) exploring life's meaning, meditation, and self-regulation in a safe community of practice.
2. **Navigating the Journey:** Weekly Zoom sessions led by a palliative care physician and guests covering advance care planning, symptom management, community resources, and more, with Q&A.

Participation is voluntary, and patients can withdraw anytime.

These programs are developed with support from the Shared Care Committee of BC, the Atleo Centre for Compassionate Leadership, and the Rural Coordination Centre of BC.

Eligibility:

- Adults (18–85) with a terminal or life-limiting diagnosis
- Able to consent and attend all sessions
- Comfortable with group sessions in English
- Access to device, internet, and email

Process:

- After referral, your patient will have a screening call and complete a consent form if interested.
- A nurse and physician will assess suitability for group participation.
- You will be informed if your patient is enrolled and receive an update upon program completion or withdrawal.

Please note: This is not a medical program. Patients continue care with their primary care and specialist teams.

Please contact one of us if you have any questions.

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Living Consciously with Terminal Illness – Referral Form

Please fax this form to: 1-236-800-7009

Referring provider: _____ MSP: _____

Address: _____ Phone: _____

Referring provider email address: _____

Fax: _____

Signature: _____ Date: _____

PATIENT INFORMATION

Name _____

Preferred Phone _____ Other Phone _____

PHN _____

Address _____ City _____ Postal Code _____

Gender (most identify with): _____ Pronouns _____

Date of Birth _____

****Email**** _____

Patient diagnosis: _____

Medical Conditions _____

Medications _____

Allergies _____

Is there anything specific that we should know about this patient?

Please fax this form to: 1-236-800-7009