Providence HEALTH CARE

REPRODUCTIVE MENTAL HEALTH PROGRAM REFERRAL

Psychiatry Referral

St. Paul's Hospital - Room 2B-185, 1081 Burrard Street, Vancouver, BC V6Z 1Y6
Telephone: 604-806-8589 Fax: 604-675-2666

(FOR OFFICE USE ONLY)

APPOINTMENT: _____ / _____ / _____
Date Time Doctor:

Date of Referral: _____

PATIENT INFORMATION (please print clearly)

Name: _____ Maiden name: _____
last middle first

Birthdate: (dd/mm/yyyy)_____ PHN: _____

Address: _____

City: _____ Postal Code: _____

Phone (Home): _____ (Cell): _____

IS THIS PATIENT A RE-REFERRAL?

☐ No ☐ Yes - If yes, seen at which location?

☐ St. Paul's Hospital ☐ BC Women's Hospital

Seen there by Dr. _____ Date seen: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Billing #:_____

Office Phone: _____ Fax: _____

Office address:_____ Email: _____

Family Physician: _____ Billing #:_____

Phone: _____ Fax: _____

REFERRALS WILL ONLY BE PROCESSED IF PAGE 2 IS COMPLETED IN FULL.

WE CANNOT OFFER APPOINTMENTS TO PATIENTS ALREADY ACCEPTED TO ANOTHER REPRODUCTIVE MENTAL HEALTH CLINIC.

We will contact your office with the appointment date and time.

FOR URGENT REFERRALS:

Fax completed form to the clinic (604-675-2666), then follow-up with a phone call outlining the urgency. (604-806-8589).

REPRODUCTIVE MENTAL HEALTH PROGRAM REFERRAL

Psychiatry Referral

PATIENT'S NAME: _____

Please inform the patient that there will likely be a medical student / resident working with the physician.

Is patient aware of the information above AND in agreement with this referral? ☐ Yes ☐ No

REFERRAL DETAILS (Select all appropriate boxes)

Referral Request

- ☐ Physician to physician consult (one-time)
- ☐ Medication assessment (one-time)
- ☐ Ongoing reproductive psychiatry follow-up

☐ **URGENT REFERRAL**
Fax completed form to the clinic then follow-up with a phone call outlining the urgency.
604-806-8589

Mental health problems related to:

- ☐ Pregnancy - Due date: _____
- ☐ Postpartum - Date of delivery: _____
- ☐ Breastfeeding – For how long: _____
- ☐ Pregnancy loss - Date of loss: _____ # of weeks: _____
- ☐ Infertility
- ☐ Peri-menopause / Menopause
- ☐ Pre-pregnancy
- ☐ Medication
- ☐ PMS
- Other: _____

IS SHE CURRENTLY EXPERIENCING SYMPTOMS OF:

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety / Panic Disorder
- ☐ OCD
- ☐ Psychosis
- Other: _____

DOES SHE HAVE A PRIOR HISTORY / DIAGNOSIS OF

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety / Panic Disorder
- ☐ OCD
- ☐ Psychosis
- ☐ Personality Disorder
- ☐ Other: _____

CURRENT RELATED BEHAVIOURS / ISSUES:

- ☐ Substance Abuse
- ☐ Violence
- ☐ Suicidal Ideation / Attempts
- ☐ Other: _____
- ☐ This condition is associated with: ☐ ICBC ☐ WorkSafe
- ☐ Other medical / legal matters (specify) _____

CURRENT CARE PROVIDERS: (include name)

- ☐ Psychiatrist: _____
- ☐ Psychologist: _____
- ☐ Social Worker: _____
- ☐ OB/GYN _____
- ☐ Other: _____

CURRENT MEDICATIONS

_____ _____

_____ _____

_____ _____

RELEVANT MEDICAL HISTORY / ADDITIONAL DETAILS:

_____

_____

_____