Reproductive Mental Health Program
4500 Oak Street Vancouver, BC V6H 1N4
Phone: 604 875 2025

# Referral Form for Reproductive Mental Health Program

Please Fax Completed Form to **604 875 3115**

- Our multidisciplinary program specializes in the diagnosis and treatment of psychiatric disorders in pregnancy and up to one year postpartum
- We offer telephone consultation for health care providers who want to discuss patient management, including medication use in pregnancy and breastfeeding . Call **604 875 2025** Mon-Fri 9:00 am-4.30pm or through RACE (Rapid Access to Consultative Expertise) 604-696-2131 or 1-877-696-2131
- Another resource is our website: www.reproductivementalhealth.ca
- We will contact the patient directly with the appointment date and inform your office **by fax** of the appointment
- This is a teaching hospital affiliated with the UBC Department of Medicine. Patients may be seen by a resident or a medical student

NAME: ________________________________________ TODAY'S DATE: ______________
FIRST MIDDLE LAST (AS APPEARS ON CARE CARD)

ADDRESS: ____________________________________________________________
APT/STREET # STREET NAME CITY POSTAL CODE

TELEPHONE: HOME: ____________ CELL: _____________ EMAIL: ____________________

CARECARD #: ___________________________________ BIRTH DATE: ________________
D/M/Y

REFERRING MD/NP/MW: ___________________________ BILLING #: __________________

OFFICE TEL #: __________________________________ FAX #: ____________________

**FAMILY DOCTOR***: _____________________________ PHONE #:___________________

*****We will not process the referral unless the patient has a family physician*****

PSYCHIATRIST (please provide consultation note): ______________________________

MIDWIFE: ____________________________ OB/GYN: ___________________________

MCFD INVOLVEMENT: If yes, **Social Worker**: ___________________________________________________

DOES YOUR PATIENT REQUIRE AN INTERPRETER? ☐ NO ☐ YES: _____________________________
LANGUAGE

## REASON FOR REFERRAL:

☐ **PREGNANCY:** No. of weeks: ________________________ Due Date: __________________________

☐ **POSTPARTUM: Date of delivery*:** __________________________________________________________

*****Please note: ideally referrals should be made within 8 months postpartum *****

*The following patients will be provided with a psychiatric consultation. They might also receive time-limited treatment, if required:*

☐ **PRE PREGNANCY/MEDICATION CONSULTATION**

☐ **PMS/PMDD:** This is a **one-time** group educational session only. Referrer can also call RACE line for further support (604-696-2131).

**CURRENT** psychiatric symptoms or diagnosis: ☐ **Depression** ☐ **Anxiety** ☐ **Psychosis**

☐ **Mania** ☐ **Suicidal Ideation** ☐ **Substance Abuse** ☐**Other:** __________________________

_____________________________________________________________________________________

**PAST** psychiatric symptoms or diagnosis:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

RELEVANT MEDICAL HISTORY/ADDITIONAL DETAILS:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

CURRENT MEDICATIONS:

_____________________________________________________________________________________

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