

|  |
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| **Attach Patient Label or please provide:** |
| Patient Name: |  |
| DOB: |  |
| ULI: |  |
| Patient Telephone Number: |  |
| May a detailed voicemail be left?: 🞎 Yes 🞎 No  |

**Outpatient Mental Health**

**Perinatal Outpatient Mental Health Referral Form**

**Tel 780-735-2792 Fax 780-735-2549**

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| Referring Provider: | Date of Referral: |
| Provider Phone: | Provider Fax: |

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| CLIENT MUST HAVE AT LEAST ONE OF THE FOLLOWING PROVIDERS:* Nurse Practitioner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Family Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Is client aware of referral? 🞎Yes 🞎NoDoes client have access to Zoom? 🞎Yes 🞎No |

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| --- | --- |
| **INCLUSION CRITERIA*** 18 years of age and older
* Has PCP in community
* 12-weeks to 1-year postpartum
 | **EXCLUSION CRITERIA*** Under 18 years of age
* Primary addictions disorder
* 3rd party assessments (e.g., lawyer/court, child welfare)
* Under care of a psychiatrist\*

(\*Psychiatrist to Psychiatrist consult may be arranged) |

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| **Reason for referral. Current symptoms and stressors:** |
| **Medical History/Pregnancy Complications:**Gravida \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Para \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gestational Age \_\_\_\_\_\_\_\_\_\_\_ #Weeks Postpartum \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



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**Outpatient Mental Health**

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| **Past Psychiatric History:** |
| **Psychosocial Stressors:** |
| **Current Medications (Please list ALL medications and allergies):** |
| **PLEASE ATTACH MOST RECENT EDINBURGH POSTNATAL DEPRESSION SCALE** |