CH_Misericordia_RGB

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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**

**Page 1 of 2**

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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 🞎No  Does client have access to Zoom? 🞎Yes 🞎No |

|  |  |
| --- | --- |
| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

CH_Misericordia_RGB

|  |  |
| --- | --- |
| **Attach Patient Label or please provide:** | |
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| DOB: |  |
| ULI: |  |

**Outpatient Mental Health**

**Perinatal Outpatient Mental Health Referral Form**

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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** |