Covenant Health Misericordia

Perinatal Outpatient Mental Health Referral Form

Rm 201, Mother Rosalie Health Services Building
16930 – 87 Avenue Edmonton, AB T5R 4H5

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

Attach Patient Label or please provide:

Patient Name: _____

DOB: _____

ULI/PHN: _____

Patient Tel Number: _____

May a detailed voicemail be left? ☐ **Yes** ☐ **No**

Referring Provider:	Date of Referral:
Provider Location/Address:	Provider Tel:
	Provider Fax:

CLIENT MUST HAVE AT LEAST ONE OF THE FOLLOWING PROVIDERS:

- Nurse Practitioner Name: _____ Tel/Fax_____
- Family Doctor Name: _____ Tel/Fax_____

Is Family Doctor/Nurse Practitioner aware of and agreeable to referral? ☐ **Yes** ☐ **No**

Is client aware of referral? ☐ Yes ☐ No

Legal Guardian ☐ No ☐ Yes Contact Name/Tel: _____

Does client have access to Zoom? ☐ Yes ☐ No

INCLUSION CRITERIA	**EXCLUSION CRITERIA**
• 18 years of age and older • Has PCP in community • 12-weeks to 1-year postpartum • **VALID** Alberta Health Care Number	• 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) • Perinatal fetal loss/traumatic birth

Reason for referral. Current symptoms and stressors (any past psychiatric history):

Medical History/Pregnancy Complications:

Gravida _____ Para _____ Gestational Age _____ # Weeks Postpartum _____

1. **Current Medications:**

PLEASE ATTACH MOST RECENT EDINBURGH POSTNATAL DEPRESSION SCALE

Date Received: _____ Referral #: _____