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	• Under 18 years of age
• Has PCP in community	• Primary addictions disorder
• 12-weeks to 1-year postpartum	• 3rd party assessments (e.g., lawyer/court, child welfare)
• **VALID** Alberta Health Care Number	• Under care of a psychiatrist
	• Perinatal fetal loss/traumatic birth

Please note that psychiatrists do not accept direct referrals from community physicians. Psychiatrists provide consultation services at the discretion of the clinic's primary clinicians and are unable to offer ongoing follow-up care or prenatal consultations. Clients may be seen only while actively attending the clinic.

REASON FOR REFERRAL

Gravida _____ Para _____ Gestational Age _____ # Weeks Postpartum _____

Symptoms/Stressors:

Medical History/Pregnancy Complications/Psychiatric History:

Current Medications:

PLEASE ATTACH MOST RECENT EDINBURGH POSTNATAL DEPRESSION SCALE

Date Received: _____ Referral #: _____