BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Provincial Health Services Authority
Province-wide solutions. Better health.

Referral Form for BC Women's 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, through **RACE** (Rapid Access to Consultative Expertise) **604-696-2131** or **1-877-696-2131**
- Another resource is our website: http://www.bcwomens.ca/our-services/specialized-services/reproductive-mental-health
- We will contact the patient directly to book their appointment and inform your office **by fax** of the appointment
- Patients **must** be physically located in BC during any virtual appointments (Zoom or Phone)
- This is a teaching hospital affiliated with the UBC Department of Medicine. Patients may be seen by a resident or medical student.

*****Incomplete and/or illegible referrals will *NOT* be processed*****

NAME: _____ TODAY'S DATE: _____
FIRST MIDDLE LAST (AS APPEARS ON CARE CARD) D/M/Y

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

TELEPHONE: MAIN: _____ 2nd: _____ EMAIL: _____
(REQUIRED)

PHN #: _____ BIRTH DATE: _____
D/M/Y

REFERRING MD/NP/MW: _____ BILLING #: _____
(CIRCLE ONE) FIRST LAST

OFFICE TEL #: _____ FAX #: _____

FAMILY PRACTITIONER* MD/NP: _____ BILLING #:_____
(CIRCLE ONE) FIRST LAST

*****We will *NOT* process the referral unless the patient has a family practitioner for continuation of care*****

OFFICE TEL #: _____ FAX #: _____

PSYCHIATRIST (please provide consultation note): _____

MIDWIFE: _____ OB/GYN: _____

Provincial Reproductive Mental Health Program
Box 164, 4500 Oak Street, Vancouver, BC V6H 1N4
Phone: 604-875-2025 Fax: 604-875-3115

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

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

REASON FOR REFERRAL:

☐ **PREGNANCY:** No. of weeks: _____ Due Date: _____
D/M/Y

☐ **POSTPARTUM: Date of delivery*:** _____
***Please note: referrals should be made within 8 months postpartum ***

☐ **PRE PREGNANCY** (+ medication)**:** This is a **one-time** consultation only

☐ **PMS/PMDD:** This is a **one-time** group educational session only.

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:

_____

_____

_____

Your patient should continue care for their Mental Health concerns until their assessment takes place.
If a crisis situation does arise, please inform them to go to their closest Emergency Department.

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