BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

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: www.reproductivementalhealth.ca
- 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
- 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)

CARECARD #: ______________________________ BIRTH DATE: ______________
D/M/Y

REFERRING MD/NP/MW: ______________________ BILLING #: ______________
(CIRCLE ONE)

OFFICE TEL #: ______________________________ FAX #: ______________

FAMILY Practitioner* MD/NP: ____________________ PHONE #:______________
*****We will *NOT* process the referral unless the patient has a family practitioner for continuation of care*****

PSYCHIATRIST (please provide consultation note): ______________________________
MIDWIFE: ______________________ OB/GYN: ______________________

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

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

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

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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:

____

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____

RELEVANT MEDICAL HISTORY/ADDITIONAL DETAILS:

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____

CURRENT MEDICATIONS:

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

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