



## Outpatient Referral Form - BC Women's Provincial Reproductive Mental Health Outpatient Clinic

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**
- 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: \_\_\_\_\_ 2<sup>nd</sup>: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
(REQUIRED)

PHN #: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
D/M/Y

REFERRING MD/NP/RM: \_\_\_\_\_ 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 Primary Care Provider for continuation of care\*\*\***

OFFICE TEL #: \_\_\_\_\_ FAX #: \_\_\_\_\_

PSYCHIATRIST (please provide consultation note): \_\_\_\_\_

MIDWIFE: \_\_\_\_\_ OB/GYN: \_\_\_\_\_





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:** This is a **one-time** consultation only

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

**CURRENT PSYCHIATRIC SYMPTOMS OR DIAGNOSES:**

**Depression**

**Anxiety**

**Substance Use**

**Psychosis**

**Mania / Bipolar Disorder**

**Suicidal Ideation**

**Other:** \_\_\_\_\_

Crisis management should be coordinated by  
Family Physician or local Mental Health /  
Community Support

**PAST PSYCHIATRIC SYMPTOMS OR DIAGNOSES:**

\_\_\_\_\_  
\_\_\_\_\_

**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.***

