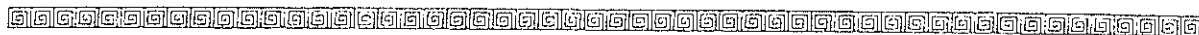


PATIENT'S NAME: _____



A) WHAT IS THE REASON FOR THE REFERRAL - Mental Health Problems related to:

- PREGNANCY - Due Date: _____
- POSTPARTUM - Date of Delivery: _____
- PREGNANCY LOSS - Date of Loss: _____ # of Weeks: _____
- INFERTILITY
- PMS
- PERI-MENOPAUSE / MENOPAUSE
- PRE-PREGNANCY / MEDICATION ASSESSMENT

B) IS THIS PATIENT CURRENTLY BEING REFERRED FOR:

- A RISK ASSESSMENT GIVEN HER PAST HISTORY / MULTIPLE RISK FACTORS OR
- CURRENT PSYCHIATRIC SYMPTOMS / BEHAVIOURS ? (please check ALL that apply)
 - Depression Bipolar Disorder Anxiety / Panic Disorder OCD
 - Psychosis Substance Abuse Violence
 - Suicidal Ideation / Attempts Other: _____

C) DOES SHE HAVE A PRIOR HISTORY / DIAGNOSIS OF:

- Depression Bipolar Disorder Anxiety / Panic Disorder OCD
- Psychosis Personality Disorder Other: _____

D) OTHER CURRENT CARE PROVIDERS: (please include name)

- Psychiatrist: _____ Psychologist: _____
- Social Worker: _____ OB/Gyn: _____
- Midwife: _____ Other: _____

PLEASE LIST CURRENT MEDICATIONS: _____

RELEVANT MEDICAL HISTORY / ADDITIONAL DETAILS: _____

Can your patient communicate adequately in English? _____ If not; which language? _____

Is this patient involved in disability claims? YES or NO (please circle)

Is this patient involved with the Ministry of Children and Families? YES or NO (please circle)

Is this patient involved with ICBC, WCB or OTHER legal matters (please circle)