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)