fraserhealth

REPRODUCTIVE MENTAL HEALTH REFERRAL

MSXX104378D Rev: May 03/16 Page: 1 of 1

Gateway #1300 - 13401 108th Avenue Surrey, B.C. V3T 5T3 Phone: (604) 953-4920 Fax (604) 953-4921

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

Patient's Full Legal Name: _____
Last First Middle

Other Name(s) (if applicable): _____

Personal Health Number: _____ **Date of Birth:** ____/____/____
DAY MONTH YEAR

Address: _____
Street City Province Postal Code

Home Phone No. _____ ☐ Okay to call **Message Phone No.** _____

Emergency Contact/Next of Kin: _____ **Phone Number:** _____

Insurance Type: ☐MSP ☐WCB ☐Out-of-Province ☐Self-Pay ☐Other: _____ RCMP or Armed forces #: _____

Interpreter Required: ☐ **No** ☐**Yes Language:** _____

Reason for Referral:

☐ Pre-Pregnancy/Medication Assessment
☐ Pregnancy: Due Date: _____
☐ Postpartum: Date of delivery: _____
Breast feeding? ☐ No ☐ Yes
☐ Risk Assessment/Opinion due to past history or multiple risk factors
☐ Pregnancy Loss: Date of Loss: _____

Type of Referral Requested:

☐ Psychiatric Assessment
☐ Individual Counselling
☐ Group Counselling

Current Symptoms:

_____	☐ Mild	☐ Moderate	☐ Severe	☐ Functioning affected
_____	☐ Mild	☐ Moderate	☐ Severe	☐ Functioning affected
_____	☐ Mild	☐ Moderate	☐ Severe	☐ Functioning affected

Current Medications:

_____
_____

Allergies:

_____
_____

History or Diagnosis of: (Provide supportive documents if available)

☐ Depression ☐ Substance Abuse/Addictions ☐ OCD
☐ Bipolar Disorder ☐ Personality Disorder ☐ Other: _____
☐ Psychosis ☐ Anxiety/Panic Disorder

Current Risk Concerns:

☐ Substance Abuse ☐ Violence ☐ Suicidal Ideation/Attempts ☐ Other: _____
☐ MCFD involved

Other Care Providers:

☐ Psychiatrist: _____ ☐ Therapist: _____ ☐ Social Worker: _____
☐ OB/GYN: _____ ☐ Midwife: _____ ☐ Other: _____

Family Physician (if different from referring source)
Name: _____
MSP #. _____
Phone: _____ Fax: _____
☐ Patient has no GP/NP

Referring Health Care Provider:
Name: _____
MSP #. _____
Phone: _____ Fax: _____
☐ GP ☐ Specialist ☐ NP ☐ Hospitalist
☐ ER ☐ Other

Referring Practitioner Signature: _____ **Date of Referral:** _____