



REPRODUCTIVE MENTAL HEALTH REFERRAL



MSXX104378D

Rev: May 03/16

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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: _____

<p>Reason for Referral:</p> <input type="checkbox"/> Pre-Pregnancy/Medication Assessment <input type="checkbox"/> Pregnancy: Due Date: _____ <input type="checkbox"/> Postpartum: Date of delivery: _____ Breast feeding? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Risk Assessment/Opinion due to past history or multiple risk factors <input type="checkbox"/> Pregnancy Loss: Date of Loss: _____	<p>Type of Referral Requested:</p> <input type="checkbox"/> Psychiatric Assessment <input type="checkbox"/> Individual Counselling <input type="checkbox"/> Group Counselling
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Current Symptoms:

_____	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Functioning affected
_____	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Functioning affected
_____	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Functioning affected

<p>Current Medications:</p> <p>_____</p> <p>_____</p>	<p>Allergies:</p> <p>_____</p> <p>_____</p>
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History or Diagnosis of: (Provide supportive documents if available)

<input type="checkbox"/> Depression	<input type="checkbox"/> Substance Abuse/Addictions	<input type="checkbox"/> OCD
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Psychosis	<input type="checkbox"/> Anxiety/Panic Disorder	

Current Risk Concerns:

<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Violence	<input type="checkbox"/> Suicidal Ideation/Attempts	<input type="checkbox"/> Other: _____
<input type="checkbox"/> MCFD involved			

Other Care Providers:

<input type="checkbox"/> Psychiatrist: _____	<input type="checkbox"/> Therapist: _____	<input type="checkbox"/> Social Worker: _____
<input type="checkbox"/> OB/GYN: _____	<input type="checkbox"/> Midwife: _____	<input type="checkbox"/> Other: _____

<p>Family Physician (if different from referring source)</p> Name: _____ MSP #: _____ Phone: _____ Fax: _____ <input type="checkbox"/> Patient has no GP/NP	<p>Referring Health Care Provider:</p> Name: _____ MSP #: _____ Phone: _____ Fax: _____ <input type="checkbox"/> GP <input type="checkbox"/> Specialist <input type="checkbox"/> NP <input type="checkbox"/> Hospitalist <input type="checkbox"/> ER <input type="checkbox"/> Other
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Referring Practitioner Signature: _____ **Date of Referral:** _____