



fraserhealth

REPRODUCTIVE MENTAL HEALTH REFERRAL

MSXX104378D

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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 CLEARLYPatient's Full Legal Name: _____
Last First Middle

Other Name(s) (if applicable): _____

Personal Health Number: _____ Date of Birth: _____ / _____ / _____
DAY MONTH YEARAddress: _____
Street City Province Postal CodeHome 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:

- | | | | | |
|-------|-------------------------------|-----------------------------------|---------------------------------|---|
| _____ | <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 |

Current Medications:

Allergies:

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:

- ☐ 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: _____