Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

Ambulatory Perinatal Mental Health Referral Form

Department of Psychiatry
700 University Avenue, Toronto, Ontario M5G 1Z5
Tel: (416) 586-4800 ext. 8325 Fax: **(416) 586-8596**

Name:

MRN:

Address:

DOB:

OHIP:

Tel: **Are telephone messages ok?: ☐Yes ☐ No**

Date _____ YYYY / MM / DD

Telemedicine Referral ☐Yes ☐No

Is patient consenting to referral? ☐Yes ☐ No

PLEASE PRINT CLEARLY – INCOMPLETE REFERRALS WILL BE RETURNED

Past psychiatric documentation/records attached (**required** for telemedicine referrals): ☐ Yes ☐ No

Referring Physician Information
Name _____
Billing # _____
Address _____
Phone (_____) _____
Fax (_____) _____

Family Physician Information (if not referring physician)
Name _____
Billing # _____
Address _____
Phone (____) _____
Fax # (_____) _____

Obstetrical History

G	P	A	EDC

Please check all that apply:

☐ Pregnancy..... Gestational age_____ High Risk - Details _____

☐ Pregnancy Termination ☐ Loss Date_____

☐ Postpartum ..... Delivery Date _____ ☐Baby in NICU

Patient previously followed by Mount Sinai Hospital PNMH Program: ☐Yes ☐No

Has patient delivered/will be delivering at MSH: ☐Yes ☐No

Reason for Referral: (We can see patients with the following *concerns:*)

☐ Pre-conception consultation

☐ Post-Partum Prevention (please describe previous episodes or significant psychiatric history)

☐ Active psychiatric symptoms: (please check all that apply)

SYMPTOMS IDENTIFIED					
Depression	☐ sadness/crying	☐ guilt/shame	☐irritability/anger	☐ loss of interest	☐poor self-esteem
Mania	☐ sped up	☐ thoughts racing	☐ not sleeping		
Anxiety	☐ intrusive thoughts	☐ panic	☐ excessive worry	☐ fear of being alone with baby	
Substance Abuse	☐ marijuana	☐ alcohol	☐ street drugs	☐ prescription drugs	
Risk Assessment	☐ to baby	☐ to self	☐ active	☐ plan	☐ intent
Psychosis	☐ hallucinations	☐ delusions	☐ bizarre behavior		
Other(s)					
Duration	_____ days	_____ weeks	☐ increasing	☐ decreasing	☐ same
Onset					

Current Medications: _____

_____

Other Involved Mental Health Professionals: _____

Referral completed by_____ Telephone (_____) _____

The Ambulatory Perinatal Mental Health Program will contact your patient directly to arrange an appointment