



**Perinatal Mental Health Program:
Psychiatric Care for Adults During Pregnancy And
The Postpartum Period 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: _____

Date _____ YYYY / MM / DD

Is patient consenting to this referral? Yes No

Are tel messages ok?: Yes No

PLEASE PRINT CLEARLY – INCOMPLETE REFERRALS WILL BE RETURNED
***If the patient has a current psychiatrist, a referral must come from the psychiatrist

Referring Physician Information

Name _____
Billing # _____
Address _____
Phone (_____) _____
Fax (_____) _____

Family Physician Information (if not referring physician)

Name _____
Billing # _____
Address _____
Phone (_____) _____
Fax (_____) _____

Please select only ONE patient type: Pregnant/Postpartum Patient Partner

Patient Information

G P A EDB

Please check all that apply (for either perinatal patient or partner):

- Preconception
- Pregnancy Gestational age: _____ weeks High Risk - Details _____
- Pregnancy Termination Loss Date _____
- Postpartum Delivery Date _____ Baby in NICU

Patient previously followed by Mount Sinai Hospital Perinatal Mental Health Program: Yes No
Has patient delivered/will be delivering at Mount Sinai Hospital: Yes No
Has patient been referred to OB Social Work: Yes No

Psychiatric History

Reason for Referral: _____

Past Psychiatric History: _____

Has the patient seen a psychiatrist in the past 6 months? Yes No If yes, please include documentation.

Other Involved Mental Health Professionals: _____

Current Medications: _____

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

Past psychiatric documentation/records attached (required for non-hospital referrals): Yes No

Referral completed by _____ Telephone (_____) _____

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