IWK Health Centre

5980 University Avenue
Halifax, NS B3K 6R8
Tel: (902) 470–8098
Fax: (902) 470–6760

Referral Form
Reproductive Mental Health Service

Please note: If you are **referring** an **inpatient** at the IWK, please use a **consult request** and fax to (902) 470–6760.

All referrals **MUST** have a general practitioner/OB–GYN/Midwife/NP listed for continuity of care purposes.
Referrals may be forwarded onto other mental health services, if necessary.

Date (yyyy/mon/dd):_____

Is the patient aware of and in agreement with this referral? ❏ Yes   ❏ No

Referrals are triaged based on clinical urgency, which is determined by information obtained from this form.

PATIENT INFORMATION (*Please Print*):	Full Legal Name
Address	Contact #
	Okay to Leave Message: ❏ Yes ❏ No
DOB (yyyy/mon/dd)	Alt. Contact #
HC# Exp (yyyy/mon/dd)	Okay to Leave Message: ❏ Yes ❏ No
REFERRING PRACTITIONER INFORMATION:	Billing #
Name	Tel #
Address	Fax #
	Signature:

REASON FOR REFERRAL (*Please Print*):	G P A_____
Medication Consultation ❏ Yes ❏ No	Pregnant? GA? EDC
	Postpartum ❏ Yes ❏ No Delivery Date
	Does the Patient require an Interpreter ❏ Yes ❏ No
	Preferred Language:

Expectation of Consultation: (*continue on page 2, if necessary*)

DIAGNOSTIC CONCERNS (IN CONTEXT OF ABOVE REASONS FOR REFERRAL AND EXPECTATION OF CONSULTATION)

❏ Major Depressive Disorder   ❏ Anxiety Disorder   ❏ Psychotic Disorder   ❏ Other (please indicate)

Details: (*symptoms, level of functioning, etc.*) Continue on page 2, if necessary

Current Medications:	Relevant History (include both psychiatric and medical):

Additional Notes (if necessary):

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