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

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**

Date _____ YYYY / MM / DD

Name:

MRN:

Address:

DOB:

OHIP:

Tel:

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	☐ 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					

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