



Bradma

**Women's Mental Health Program  
REPRODUCTIVE LIFE STAGES REFERRAL**

Fax 416.323.6356

Telephone 416.323.6400 x 5635

**Patient must call 416.323.7715 to complete a telephone Intake within four weeks of the referral being accepted, after which an assessment appointment will be scheduled. We do not provide long term care.**

This form is used for screening purposes.

Please provide detailed information in order to facilitate timely provision of service.

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**Patient Information**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Health Card Number \_\_\_\_\_ Version Code \_\_\_\_\_

Telephone Numbers 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

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**Referral Source Information**

Attending Physician \_\_\_\_\_ OHIP Billing # \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

If referral is made by a non-physician, we also require a referral from her family doctor. Patients must have a family physician as we do not provide primary care.

Form completed by \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

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**Reason for Referral**

- Pregnancy  
- EDD \_\_\_\_\_
- Postpartum  
- Delivery Date \_\_\_\_\_
- Pregnancy Planning
- Premenstrual Syndrome/Premenstrual Dysphoric Disorder
- Premenopausal

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**Expectation of Consultation**

**Psychiatric Presentation**

	<b>Current</b>	<b>Past</b>
Major Depressive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Affective Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Generalized Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Social Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance Dependence	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive Behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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**Psychotropic Medications** (names, doses, effects)

Current:

Past:

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**Medical History**

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**Obstetrical History**

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**Family Psychiatric History**