Sunnybrook
HEALTH SCIENCES CENTRE

Women's Mood and Anxiety Clinic: Reproductive Transitions (WMAC-RT)

OUTPATIENT CONSULTATION REFERRAL

Print and Fax to: 416 - 480-7842
Within Sunnybrook hospital: Use full 10 digits to fax

Date: _____ (MM/ DD/ YYYY)

INCOMPLETE OR UNCLEAR FORMS WILL BE RETURNED

We are unable to provide urgent assessments, long-term treatment, or consultations for legal/ insurance/workers compensation issues.

PATIENT INFORMATION **MRN:**		Contact Number: Can a message be left? Y/N
Last Name:		First Name:
Address:		Postal Code:
Date of Birth (mm/dd/yyyy):		OHIP #:
REFERRING PHYSICIAN INFORMATION		**Address/Physician Stamp:**
Referring Physician:		
MD Billing #:		
Telephone:	FAX:	

REASON FOR REFERRAL (please check all that apply) **G _____ P _____ A _____**	
☐ Contemplating Pregnancy	☐ Postpartum → Gestational weeks at delivery: _____ Delivery Date: _____(mm/dd/yyyy)
☐ Pregnant → Gestational age: _____ Due date: _____ (mm/dd/yyyy) / High Risk: Y / N	Location of Delivery:
☐ Pregnancy Termination ☐ Perinatal Loss Date: _____ (mm/dd/yyyy)	Name of Obstetrician/ Obstetrical Health Care Provider:

☐ Premenstrual Dysphoric Disorder	☐ Medication Consultation
☐ Peri/Post-menopausal	☐ Other

DIAGNOSTIC CONCERNS (in context of above reasons for referral)

☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Anxiety Disorder ☐ Psychotic Disorder

Details:

DETAILS OF REFERRAL

_____

_____

MEDICATIONS:	**MEDICAL HISTORY:**

Does patient currently have a psychiatrist? ☐ Yes ☐ No
Other mental health services involved? ☐ Yes ☐ No
Specify:

Name of provider:
Telephone:
CAS involved? ☐ Yes ☐ No

Does referring physician agree to implement/monitor recommendations? ☐ Yes ☐ No

PLEASE ENSURE ALL PATIENT DEMOGRAPHICS AND PHYSICIAN REFERRAL INFORMATION IS COMPLETE
The WMAC-RT will contact your patient directly to arrange an appointment.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐