New Outlook Psychiatric Prenatal Med Management Referral Form

Return via FAX: 888-789-8394 or EMAIL: btownoffice2@newoutlookcc.org

PATIENT DEMOGRAPHIC INFORMATION

*Patient's Name ____

Address (incl zip): ____

*Main Phone#: ______________________ (name of contact if a guardian) Alt Phone#: ______________________

*Email: ______________________ Marital Status: Single Married Divorced Widowed

SSN: ______________________ *DOB: _____/_____/_____ *Sex: ______ **ATTACH INSURANCE CARD**

*Insurance Subscriber Name and DOB______________________________________

Emergency Contact Name: ______________________ Relationship: ____________ Contact #: ______________________

Current Primary Care Physician: ______________________ Phone #: ______________________

Therapist (if applicable): ______________________ Contact Info: ______________________

OB/GYN:______________________ Phone: ______________________ **SIGN A RELEASE OF INFORMATION**

Previous (Dates)/Current Psych Med Prescriber: ______________________ Contact:______________________

****Please have patient sign a Release of Information for current providers (if not current than past providers) and send with completed referral form. ****
Release of Information forms and Referral forms can be found on www.newoutlookcc.com under the "forms" tab.**

Reason for Referral: ____

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Diagnosis: History (H) or Current (CRNT): Preconception (PC) Perinatal (PN) Postpartum (PP)

Diagnosis:	**Time frame:** (PC) (PN) (PP)	**HX or Current**	**Diagnosis:**	**Time Frame:** (PC) (PN) (PP)	**HX or Current**	**Diagnosis:**	**Hx or Current**
Anxiety	PC PN PP	H CRNT	Depression	PC PN PP	H CRNT	PTSD	H CRNT
Vitamin Deficiency	PC PN PP	H CRNT	Psychosis	PC PN PP	H CRNT	Bipolar (I or II)	H CRNT
High/Low BP:	PC PN PP	H CRNT	Preeclampsia:	CRNT Preg / HX	H CRNT	OCD	H CRNT
Other:			Other:			Anorexia	H CRNT
Other:			Other:			Bulimia	H CRNT

Relevant Medical Diagnoses: ____

Past Pregnancy complications/Info:____

Is the other parent or a partner involved? Yes / NO / SKIP____ Are they a strong support?______________________

Relevant Social Factors: ____

Number of pregnancies: __________, # of Live Births _________, # of Miscarriages: __________, # of Stillbirths_________

Past / Current Medical AND Psychiatric History and Treatment (circle appropriately: History of-HX, Current-CRNT)

Former patient in clinic/Release? __ Yes__NO__HX__CRNT Details:______________________________

Violence, Suicide attempts, Psychiatric Hospitalizations, Psychosis or Delusions (Yes__NO__HX__CRNT)? ______________

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Current/Historical Psychiatric Symptoms: ____

____

Current suicidal/homicidal thoughts? No Yes Details______________________________

Additional Information: ____

Current Psychiatric Medications (name & dose, attach list if preferred) ______________________

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Signature of Referral Source: ______________________________ **Date/Time**__________________