

REFERRAL FOR PERINATAL THERAPY GROUP

Fax to: (604) 983-6883 Attention: Susan Walter, Public Health Program Leader

DATE: _____

Client Name _____

Carecard # _____

Address _____

Phone Number _____

Is client aware of referral _____ yes _____ no

Prenatal: _____ Postpartum _____

Pertinent Medical History _____ EPDS _____

Client will be contacted by the public health nurse to discuss the group. Update will be provided to the referring care provider at 10-12 weeks.

Physician/Psychiatrist/Midwife/PHN: _____

Address: _____

Phone Number _____

Fax Number _____

Signed
(physician/psychiatrist/midwife/PHN)