PERINATAL REGISTRAR CLINIC
GP REFERRAL FORM

This Bulk-bill (Registrar) Clinic is means-tested for women who cannot afford a private consult

Please ensure **ALL FIELDS** are completed and legible to enable us to process this referral.
Fax to 02 9334 3850 or email bmc.reception@sjog.org.au; appropriate referrals will be offered an appointment; otherwise the Psychiatry Registrar will contact you with alternative referral suggestions.

Referral Date: ___ / ___ / _______

GP Name: ____ **GP Phone**: ______________________

GP address: ____

GP provider number: _____________________**GP secure Email:** ___________________________

Patient's Name:____________________________________ **Date of birth:** ___ / ___ / _______

Patient's Address:_________________________________ **Mobile #:**________________________

Paid maternity leave: Yes/ No **Partner: Yes/ No** **Partner employed: Yes/ No**

Partner occupation:_________________________________ **Health Concession Card: Yes/ No**

Ante/ Postnatal Weeks (circle as appropriate): _______________

Todays EPDS score: ________**/30 Q10:** _______ **ANRQ score:**________________

Current Mental Health issues & reason for referral to Registrar Perinatal MH Clinic:

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Past Mental Health history (incl. treatment):

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Relevant Medical/Obstetric History:____

Current Psych Medications: (incl. recent changes): _______________________________________

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Referral Criteria: please ensure you tick as appropriate:

- Pregnant and women up to *12 months* postnatal ☐
- Management Planning ☐
- Short-term medication management or Advice re use in pregnancy & Breastfeeding ☐
- Referral to the outpatient PND & COS groups at St John of God Burwood Hospital ☐

NB: For ongoing management, patient is referred back to her GP or private psychiatrist.