PERINATAL CONSULTATION CLINIC REFERRAL

UR Medicine Perinatal Consultation Clinic (PNCC)
125 Lattimore Road, Suite 150, Rochester, NY 14642 Phone: (585) 275-7604 Fax: (585) 242-8707

PATIENT:

Name: _____ DOB: _____ Sex: _____

Address: _____ Phone: _____

REFERRING PROVIDER:

Name: _____ Phone: _____ Fax: _____

IDENTIFIED PRESCRIBER: (if different than referring)

Name: _____ Phone: _____ Fax: _____

Does the patient have an existing psychiatrist/psychiatric nurse practitioner?
□ No □ Yes – please contact that person first and indicate their contact info:

Name: _____ Phone: _____ Fax: _____

CLINICAL INFORMATION:

Reason for Referral / Psychiatric Diagnoses: _____
_____
_____

□ Planning to Conceive/Breastfeed
□ Currently Pregnant (gestational age / due date)
□ Currently Lactating/Breastfeeding
□ Recently Postpartum
□ Pre-Menstrual Dysphoric Disorder

Medication History (can fax clinical summary containing medication history to 585-242-8707 instead of completing below)

Current Medications (please include name, dose duration of treatment, and clinical effect if known)

_____
_____
_____
_____
_____
_____
_____

Past Medication Trials (please include name, dose, duration of treatment, clinical effect, and side effects if known)

_____
_____
_____
_____
_____
_____
_____