# 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)

_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________