If you would like to refer your patient for a consult or counselling, fax this form to

403-453-0337 or your client can self refer [www.birthnarratives.ca](http://www.birthnarratives.ca). Make sure to inform your patient this is a *fee for service* centre. They may use their benefits or contact us directly if finances are a concern. You may find this referral form on the website as well.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source: Name/Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR THE REFERRAL

Prenatal mental health

Postpartum mental health

Fear of childbirth

Fertility and mental health

Childbirth trauma

Pregnancy loss

Suicidal thoughts/ideation

EMDR/trauma therapy

Any other symptoms you want us to know about:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW WOULD THE CLIENT LIKE TO BE CONTACTED BY US

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Text \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

They will contact us and self refer