

PATIENT REFERRAL FORM

WOMEN’S WELLNESS & COUNSELING SERVICE

UNIVERSITY OF IOWA HOSPITALS & CLINICS

Please complete the items below in their entirety. All information provided will be kept confidential. By transmitting this form, you are confirming that your patient understands the purpose and content of this referral, and has consented to be contacted by Service staff. Please note: **We accept only referrals from providers, and are not able to accept patient self-referrals**

When completed, **fax this form to 319-353-7788**

- The Women’s Wellness and Counseling Service provides psychiatric and psychological services to women who are pregnant, postpartum, or planning a pregnancy.
- Referral information will be reviewed by Service staff as soon as possible. You may be contacted to provide additional information.
- Generally within 3 business days, your patient will be contacted to discuss evaluation options.
- Please keep in mind that our triage system will give the most urgent cases the highest priority, so there may be instances when your patient will wait longer than 3 days to be seen in the clinic. We will constantly strive to provide the most timely and efficient service that we are able.
- Our service is not designed to address mental health emergencies or extremely urgent cases. These patients should be referred to other resources or providers such as the Adult Psychiatry Clinic or the Emergency Service at UIHC.
- If you have questions about this form or about the WWC, call **319-356-2294** or see our web site (<http://www.uihealthcare.com/depts/womenswellness/index.html>). Thank you.

Patient Name: _____

Previous Names: _____ Patient Date of Birth: _____

UIHC Patient, Past or Present? yes ____ no ____ If **YES**, Please Provide Hospital# (MRN): _____

Current Medication(s): _____

Current Diagnoses or Medical Conditions: _____

Does the Patient Have Insurance? yes ____ no ____ If **YES**, Please List: _____

Patient Contact Information:

Home Phone#: _____ Work Phone#: _____ Cell Phone#: _____

Address: Street/Number: _____

City/State: _____ Zip Code: _____

Emergency Contact: Name _____ Phone#: _____

CONTINUED ON NEXT PAGE →

Physician/Provider Contact Information:

Your Name: _____

Hospital/Clinic/Agency Where You Work: _____

Address: Street/Number: _____

City/State: _____ Zip Code: _____

Work Phone#: _____ Cell Phone#: _____ Pager#: _____

Reason For Referral:

Evaluation for Therapy:	_____
Medication Evaluation:	_____
Pre-Pregnancy Planning:	_____
2 nd Opinion/Consultation:	_____
Other:	_____

Other Relevant Information:

Would You Like to Be Contacted After Initial Patient Evaluation is Completed? yes _____ * no _____

** (Clinic Staff Will Contact You Pending Patient Consent)*

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