



**Indigenous Perinatal Mental Health Worker
Client Referral Form**

Clients Name: _____ **Referral Date:** _____

Spirit Name _____ **Meaning of Spirit Name** _____

Marital Status

Common-law Single Partner

Self-Identification:

Band: _____

First Nations (status) First Nations (non-status) Metis other (please identify): _____.

Partner/child Self Identification:

Band: _____

First Nations (status) First Nations (non-status) Metis other (please identify): _____.

Do they presently have a Family Physician/Nurse Practitioner yes No

Please Provide Family Physician contact information: _____.

Is the Client expecting at this time? Please Specify Trimester the client is in at the time of this referral? _____

How many Children does the client currently have? _____

Please specify ages of each child _____

What are the concerns for which client is seeking support?

System Navigation _____ Please specify clients involvement with Community Agencies

Housing
Support _____

Baby/Parenting Supports _____

Traditional Healing _____

Good Health teachings _____

Counselling/emotional support _____

Please specify areas of concerns for seeking counselling:

Bereavement for perinatal loss (at any stage in perinatal period) /Abortion.

Loss of child through Apprehension/Adoption Yes/No _____

Perinatal Moods disorders Symptoms are Present (Anxiety/depression/OCD/PTSD/Psychosis)

Fertility/Infertility (Individual and or/ Partner counselling)

Pregnancy/Labor/Delivery (Trauma/Anxieties/Concerns)

Other: _____

Referral Information

Referral Name/Agency _____

Referral Contact Number/Email Address: _____

Please contact me if you have any additional questions. Please send all Referrals to:

Melissa Maidment

Indigenous Perinatal Mental Health Worker

CSC CHIGAMIK CHC

(Centre de santé communautaire CHIGAMIK Community Health Centre)

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