16220 Frederick Road | Suite 502
Gaithersburg | Maryland 20877
Phone: 301 978 9750 | Fax: 301 978 9753
main@we-aspire.org | www.we-aspire.org

REFERRAL FORM FOR HEALTHY MOTHERS HEALTHY BABIES PROGRAM

Revised August 2014

REFERRAL INFORMATION

Referral Worker:_____ Referral Agency:_____

Worker's Phone:_____ Fax:_____ Email:_____

Referral for a mental health assessment and possible treatment based on:

☐ A screen shows possible PPD; Please indicate which screen and score:_____

☐ Observation that indicates possible PPD, that includes maternal relationships and/or emotional issues that may interfere with the mother's ability to care for her child.

Please fax this form, completed screen instrument if one was done, other pertinent information, and a signed consent form indicating that Referrer and Aspire Counseling can communicate TO: 301.978.9753

CLIENT INFORMATION

Name_____ DOB:_____ Baby: EDC/DOB_____

Address:_____

Ph #'s:cell:_____ other:_____ Email address:_____

CLIENT ASSESSMENT *Please answer as much as you know of the client. Skip those you cannot answer.*

☐ Uninsured ☐ Insured, Medicaid #_____	Current medications? ☐ No ☐ Yes, medications:
Does the client have thoughts of harming herself/ others; ideation/plans/preparation? ☐ No ☐ Yes, explain:	How is the client's physical health? ☐ Good ☐ Fair ☐ Current or chronic issues:
Has client had mental health treatment in the past or hospitalizations for mental health reasons? ☐ No ☐ Yes, when and what issues addressed:	Did the client have a C-Section during the most recent birth? ☐ No ☐ Yes ☐ Not applicable (client is currently pregnant)
Are there concerns about possible drug and alcohol abuse? ☐ No ☐ Yes, explain:	Are there concerns about the baby? ☐ No ☐ Yes, explain:

Please briefly describe the client's symptoms, concerns, and the reason you feel therapy would be helpful.

Underline any of the following common symptoms if that helps you answer the question: *Mood:* decreased enjoyment, self-blame, anxiety, panic (including physical feelings such as heart racing, sweaty, cold, flushed), frightened, irritable, sadness, tearfulness, guilt, thoughts of being a "bad mother," hopelessness, helplessness, obsessive worries or compulsive behavior. *Behavior:* difficulty caring for physical needs of self or baby, trouble sleeping/napping when the baby is asleep, frequent trips to pediatrician or ER when there is no evident physical problem, decreased energy. *Physical symptoms*: frequent, unexplained headaches, backaches, or stomachaches.

Comments:_____

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