

Postpartum Group Referral Form

Please fax to: **416 530-6076****DATE:** _____ (mm/dd/yyyy)

We serve individuals who reside in the Unity Health catchment area and/or delivered with a Unity Health affiliated practitioner and are at risk for, or who are currently experiencing, symptoms of postpartum anxiety and/or depression following delivery and up to one year postpartum.

This group is not suitable for individuals with a psychotic illness or active substance use.

Patients will be screened to assess suitability for this group. If patients require diagnostic and/or medication consultation, they need to be referred separately to St. Joseph's Health Centre, Pregnancy and Postpartum Mental Health Program, Collaborative Care Clinic.

PATIENT INFORMATION:

Name: _____

DOB: _____ (mm/dd/yyyy)

EDD/Delivery Date: _____

HC #: _____

Address: _____

Email: _____

Contact Phone #'s: _____

Confidential message can be left: Yes / No

REASON FOR REFERRAL:

REFERRAL SOURCE INFORMATION:

Name: _____

Telephone: _____ Fax: _____

Billing #: _____

FAMILY PHYSICIAN:

Name: _____

Telephone: _____ Fax: _____

Referrals for this group can only be accepted from physicians, nurse practitioners and midwives