FATHERS MENTAL HEALTH

Referral Form

St. Joseph's Health Centre
30 The Queensway, Toronto, On, M6R 1B5
Tel: (416) 530-6000 ext. 4518 Fax: **(416) 530-6393**

Date: _____
YYYY / MM / DD

Clearly Imprint Patient Identification

Name:

DOB:

Postal Code:

OHIP:

Tel:

Email:

Are telephone messages OK? ☐Yes ☐No

**** PLEASE ENSURE PATIENT DEMOGRAPHICS AND PHYSICIAN REFERRAL INFORMATION IS COMPLETE + PREVIOUS PSYCHIATRIC RECORDS ARE ATTACHED ****
INCOMPLETE/UNCLEAR FORMS WILL BE RETURNED

Referring Physician Information

Name _____
Billing # _____
Address _____
Phone (_____) _____
Fax (_____) _____
Email _____

Family Physician Information (if not referring physician)

Name _____
Address _____
Phone (_____) _____
Fax (_____) _____

Father's Demographic Data

Please check all that apply

☐Expectant Father (Partner's Due Date: _____)
☐Father (child < 1 year old)
☐Perinatal loss

Reason for Referral (Psychiatric Concerns):

_____
_____
_____

Psychiatric History (MUST include any psychiatric reports or documents) _____

_____

Current Medications _____

Other Involved Mental Health Professionals (Psychiatrist, Social Worker, Therapist, CAS, etc.)

_____

UNITY HEALTH TORONTO

The Perinatal Mental Health Program will contact your patient directly to arrange an appointment.