



**Referral Form**

Fathers' Mental Health Service

700 University Avenue, Toronto, Ontario M5G 1Z5

Tel: (416) 586-4800 ext. 8325 Fax: (416) 586-8596

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.)**  
\_\_\_\_\_



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