MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

Ambulatory Perinatal Mental Health
Referral Form
Department of Psychiatry
700 University Avenue, Toronto, Ontario M5G 1Z5
Tel: (416) 586-4800 ext. 8325 Fax: **(416) 586-8596**

Clearly Imprint Patient Identification

Name:

DOB:

Postal Code:

OHIP:

Tel:

Patient's Email Address:

Date _____
YYYY / MM / DD

Are telephone messages OK? ☐Yes ☐No

PLEASE PRINT CLEARLY

Referring Physician Information

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

Email: _____

Family Physician Information (if not referring physician)

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

Obstetrical History

G	P	A	EDC

Please check all that apply

☐Pregnancy ..... Gestational age _____ ☐High Risk – Details _____

☐Pregnancy Termination ..... Date _____

☐Perinatal Loss..... Date _____

☐Postpartum..... Delivery Date _____ ☐Baby in NICU

☐Other (specify) _____

Reason for Referral (*Psychiatric Concerns*) _____

_____

_____

Psychiatric History_____

_____

_____

Current Medications _____

Other Involved Mental Health Professionals

Social Worker _____ Toronto Public Health _____

Other (*e.g. psychiatrist, psychologist, counsellor, CAS*) _____

Urgent Care Clinic (******for Mount Sinai Hospital patients only******)
Criteria for referral

☐Within 4 weeks of EDC ☐Patient lives outside of GTA

☐Active psychiatric concerns with no psychiatric care (*specify*):

Referral completed by_____ Telephone (_____)_____

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