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ributatory Permatat W Eferral Form	Address				
partment of Psychiatry		Address	•		
00 University Avenue, Toronto, Ontario M5G 1Z5 el: (416) 586-4800 ext. 8325 Fax: <b>(416) 586-8596</b>		DOB:			
en. (410) 380-4600 ext. 6323 Fax. (410) 380-6330		OHIP:			
)ate	YYYY / MM	/ DD Tel:		Are telephone n	nessages ok?: 🗆 Yes 🗀 N
elemedicine Referra	al □Yes □No	Is	oatient consenting	to referral?	∃Yes □ No
	PLEASE PRINT CLE				
ast psychiatric docu	mentation/records at	ttached ( <u>required</u>	for telemedicine re	eterrals): 🗆 Yes	5 □ No
Referring Physician	Information	F			ot referring physician)
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fax ( )			Fax # ()		
ostetrical History					
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Please check all that	apply:				
☐ Pregnancy	Gestatio	nal age	High Risk - Details		
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•	ollowed by Mount Sir		-		
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