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**

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 RETURNS

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 (MUST include any psychiatric reports or documents) _____
_____

Current Medications _____

Other Involved Mental Health Professionals

Social Worker _____ Toronto Public Health _____
Other (*e.g. psychiatrist, psychologist, counsellor, CAS*) _____

Referral completed by _____ Telephone (_____) _____

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