FATHERS MENTAL HEALTH

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

This service is offered exclusively to fathers whose mental health is at risk of interfering with fatherhood. A consultation will include a psychiatric assessment as well as exploration of family functioning.

**** 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)
☐Late Prenatal 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.)

_____

MOUNT SINAI HOSPITAL
Bright Minds. Big Hearts. The Best Medicine.

ST JOSEPH'S HEALTH CENTRE TORONTO

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