FATHERS MENTAL HEALTH

Referral Form

St. Joseph's Health Centre
30 The Queensway, Toronto, On, M6R 1B5
Tel: (416) 530-6000 ext. 4518 Fax: **(416) 530-6393**

Date: 2024/01/05
YYYY / MM / DD

Clearly Imprint Patient Identification

Name: Josephine Olaver
DOB: 08-19-1971
Postal Code: 404-32 Maynard Avenue
OHIP: 2694180690-YK
Tel: 4168899061
Email: jolaver68@gmail.com

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 Lars Stanmyde
Billing # 656381
Address 30 The Queensway TOR/ON/M6R 1B5
Phone (416) 530 6100
Fax ( )
Email

Family Physician Information (if not referring physician)

Name Bill Neelunaite
Address 15 Roncesvalles Ave M6R 2K2
Phone (416) 925 6126
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):

generalized anxiety
disrupted sleep/insomnia

Psychiatric History (MUST include any psychiatric reports or documents) SEE ATTACHMENT

Current Medications Ativan - prev. BuSpar

Other Involved Mental Health Professionals (Psychiatrist, Social Worker, Therapist, CAS, etc.)

psychotherapist (referring)

UNITY HEALTH TORONTO

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