HUMBER RIVER HOSPITAL

Maternal and Child Program

Perinatal Social Work Referral

PATIENT INFORMATION

Patient Name:

Date of Birth (dd-mm-yyyy):

HCN:

Home Telephone Number:
( )

Work Telephone Number:
( ) extension.

Cell Telephone Number:
( )

Select assessment tool:
☐PHQ-2 ☐GAD-2 ☐EPDS

Date:_____ Score:_____

EDD:

G: _____ T: _____ P: _____ A: _____ L: _____

NND: _____ SB: _____

REFERRING DOCTOR

Name of Referring Doctor:

Telephone Number:
( ) extension.

Fax Number:
( )

Patient is aware of reason for referral: ☐ Yes ☐ No

REASON FOR SOCIAL WORK REFERRAL

(please check all boxes that apply)

- ☐ Adoption
- ☐ Family conflict/domestic violence
- ☐ Finances
- ☐ Grief and loss/bereavement support
- ☐ History of trauma/abuse
- ☐ History/current CAS involvement
- ☐ Homelessness/housing concerns
- ☐ Immigration/settlement
- ☐ Limited social support/community resources
- ☐ Mental health/coping
- ☐ Substance misuse
- ☐ Surrogacy
- ☐ Young maternal age: Age_____

☐ Additional comments:

FAX the completed form to (416) 242-1092 along with a copy of relevant antenatal findings.

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