Humber River Health

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

☐ Additional comments:

FAX the completed form to (416) 242-1137 along with a copy of relevant antenatal findings.

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