London Health Sciences Centre

Referral Form – Perinatal Mental Health Clinic

800 Commissioners Rd E.
London, Ontario
Phone (519) 667-6673
Fax (519) 519-667-6514

OFFICE USE ONLY:
Date Received: _____
Appointment Date: _____

This form is used for screening purposes, please provide all information.

Patient's Name: _____ _____
(last) *(first)*

Date of Birth:_____ / _____ / _____ **Health Card Number:** _____**Version Code:**____
(day) *(month)* *(year)*

Address: _____
(include postal code) _____

Telephone Number(s): (_____)_____ (_____)_____ **Preferred contact:**
Home **alternate** ☐ **Home** ☐ **Alternate**

Referring Provider: _____ **Date of Referral:** _____ / _____ / _____
(day) *(month)* *(year)*

Telephone: (_____)_____ **Fax:** (_____)_____ **OHIP Billing#:**_____

Provider Requested: ☐ Dr. H. Haensel ☐ Dr. V. Sharma ☐ No preference

Reason For Referral: ☐ Preconception ☐ Prenatal (indicate EDB)_____ ☐ Postpartum

_____

_____

_____

_____

_____

Other Services Received:	**Current**	**Past**
Children's Aid Services:	☐	☐
Mental Health and Addictions Services: (indicate name of individual or service)		
_____	☐	☐
_____	☐	☐
_____	☐	☐

Family Doctor: _____

Other Supports:

_____