Toronto Centre for Emotional Health
Heal. Grow. Thrive.
720 Spadina Avenue, unit 502
M5S 2T9 Toronto, ON

Perinatal Counselling Referral Form

Date of Referral: ____/_____/_____

Referring Provider Information

Name: _____

Clinic/Hospital Name: _____

Phone Number: _____

Email: _____

Patient Information

Full Name: _____

Date of Birth: _____ / _____ / _____

Phone Number: _____

Email: _____

Preferred Contact Method: ☐ Phone ☐ Email

Other: _____

Reason for Referral

☐ Perinatal Anxiety
☐ Perinatal Depression
☐ Birth Trauma Support
☐ Postpartum Adjustment
☐ Other: _____

Preferred Service Location

☐ In-Home Counselling (within catchment areas)
☐ In-Clinic Counselling
☐ Virtual Counselling

Additional Notes/Relevant Clinical Information:

_____
_____
_____
_____
_____
_____
_____

Consent & Submission

By submitting this referral, I confirm that the patient has provided consent for their contact information to be shared with the Toronto Centre for Emotional Health for the purpose of scheduling an appointment

☐ Yes, patient has provided consent.

The referring provider acknowledges that they have informed the patient that services provided by the Toronto Centre for Emotional Health are not covered by OHIP but may be covered by extended health benefits or private insurance plans. It is the patient's responsibility to verify coverage with their insurance provider before proceeding with services.

Referring Provider signature: _____

Please send the completed form to: info@torontoemotionalhealth.ca