Peterborough Regional Health Centre
1 Hospital Drive, 6th Floor,
Peterborough, ON. K9J7C6
Phone: 705- 743-2121 x2799 Fax: 705-740-8004

Referral form: Not What I Expected
Postpartum Mood Disorder Group, May 4 – June 22, 2015

Name: _____

DOB: _____

Address:

_____

Home Phone # (_____)_____ Can a message be left at this number ___Y _____N

Alternate Phone # (_____)_____ Language Spoken_____

Health Card # _____ Version Code _____

CLIENT MUST BE AWARE THAT YOU ARE MAKING THIS REFERRAL.

GROUP FACILITATOR WILL CONTACT CLIENT TO SCHEDULE A SCREENING INTERVIEW.

Please note any concerns you may have about this individual's ability to participate in this group.

_____

_____

_____

_____

Referral Source:

Name: _____

Phone#: _____**Fax#**_____

Address_____ **Postal Code:** _____

Please Fax your completed form to the Paediatric Out-Patient Clinic at (705)-740-8004

For internal use only:

_____
Appointment Date and Time