Trillium Health Partners
Better Together

Last Name: ______________	First Name: ____________________
Date of Birth (DD/MM/YYYY): ________/________/________	
Health card #: ________________________________	
MRN #: ________________________________	
CSN #: ________________________________	

Affix patient encounter label here/complete all fields if label not available.

THP use only

Perinatal Community Care Program – Referral Form

PATIENT DEMOGRAPHICS:

Last Name: ______________________ First Name: ________________________________ Date of Birth (DD/MM/YYYY): _____/_____/______

Health Card #: ____________________________________ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _______________________________________ City: ________________ Province: _____________ Postal Code: ____________

Telephone number: _________________________ Mobile number: ____________________ Email Address: _________________________

Reason for Referral (select all that apply):

- ❑ Prenatal teaching for early discharge
- ❑ Early Discharge under 24h
- ❑ Postpartum Newborn Assessment
- ❑ Postpartum Maternal Assessment
- ❑ 1:1 Breastfeeding Assistance
- ❑ Overflow from Jaundice clinic
- ❑ Postpartum class: breastfeeding, newborn care, self-care
- ❑ Bereavement Follow-Up
- ❑ Sexual health
- ❑ Other/Comments: _________________________________

Clientele Group (select all that apply):

- o High social needs
- o low socio-economic
- o Person with hearing loss
- o Person with vision loss
- o Person with disability: _______________
- o Refugee/Asylum Seeker
- o Newcomer to Canada
- o Adolescent
- o Housing issues
- o Social Services: involvement of CAS, prison, etc.
- o Mental health - specify: _____________
- o IBPOC
- o 2SLGBTQQIA+
- o Experience of trauma: before or during birth
- o No Primary Care Provider
- o Unable to get appointment with primary care provider/specialist in timely manner
- o Gendered preferred care provider
- o Other/Comments: _________________________________

Additional Information:

Referrals will be reviewed within 2 business days of receiving them. Fax to 905-813-3570
For any questions regarding the Perinatal Community Care Program, please email pccp@thp.ca or leave a message at 905-848-7350.

REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name- as listed in CPSO): ____

Address: ____________________________ City: ___________________ Province: _____________ Postal Code: ______________

Phone number: _________________ Fax number: _______________ CPSO #: ______________ Billing (OHIP) #: _______________

Signature: ____________________________________ Date: __________________