76 Grenville Street, Toronto, Ontario M5S 1B2
Telephone: 416-323-6400 Ext. 7330
Fax: 416.323.7730

SOCIAL WORK REFERRAL FORM PETER GILGAN CENTRE FOR WOMEN'S CANCERS

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: ____________________ Date of Birth: ___/___/____
DD/MM/YYYY

Health Card: ____________________ Version Code: ______

Address: ______________________________________

Telephone: _________________ Alternate: _______________

Referral Date: DD/MM/YYYY

ADDITIONAL PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Gender identity: ____________________	Name: ______________________________
Sex assigned at birth: _______________	Address: ____________________________
❑ He, Him ❑ She, Her ❑ They, Them ❑ Other:___________	Telephone: _________________ Fax: _______________
Allergies: __________________________________	Alternate report sent to: (name/contact information) ______________________
Insurance coverage/self-pay: _________________	Billing number: ___________________________
Language spoken: ____________________________	
Interpreter required: ❑ Yes ❑ No	Signature:_________________________________

REASON FOR REFERRAL - Indicate reason for referring patient and check all boxes that apply

Adjustment to Illness (Diagnosis/Treatment/Survivorship)	**Significant Distress**	**Loss and Grief/Bereavement**
❑ Assistance with navigating illness experience ❑ Fear of illness recurrence ❑ Decision making difficulties	❑ Passive suicidal or homicidal risk ❑ Self-harm behaviors	❑ Loss of a healthy body and implications (sexual health and body image) ❑ Death and dying
Mental Health Concern	**Family Dynamics**	**Functional Aspects/Tasks**
❑ Previous mental health diagnosis ❑ Current mood related challenges (sadness, anxiety, anger, stress, frustration, panic, etc.)	❑ Family dynamic challenges ❑ Relationship issues ❑ Communication challenges ❑ Assistance with speaking to children about cancer ❑ Child welfare matters	❑ Financial matters ❑ Employment ❑ Housing ❑ Transportation ❑ Access to community supports/resources

Other (please specify): ____

Please indicate timing for appointment

❑ **Urgent** (contact within 24 hours)
❑ **Routine** (contact within 1 week)

Patient informed of referral ❑ **Yes** ❑ **No** **Patient given Social Work contact information** ❑ **Yes** ❑ **No**

OTHER RELEVANT PATIENT CLINICAL INFORMATION

Please include any other relevant medical history, diagnostic/clinical information:

Fax Disclaimer: This fax transmission contains confidential information that is intended only for the Women's College Hospital Clinics. If you are not the intended recipient, you are hereby notified that any use, review, disclosure, copying, or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the sender at the telephone number provided above to arrange for the return or destruction of this document.