UNIVERSITY OF TORONTO

HEALTH & WELLNESS CENTRE

PSYCHIATRY REFERRAL FORM

700 Bay St. , 12th floor Toronto, ON, M5G 1Z6
(416) 978-8030, press option #5 ▪ **FAX (416) 978-7341**

Please note:

- Psychiatric diagnostic consultations are general in nature. We do NOT offer specific stand-alone subspecialty diagnostic consultations or psychoeducational testing around ADHD or ASD.
- We offer psychiatric consultations and brief episodes of care, to help students meet their academic goals, returning them to the referring clinician/community care as appropriate.
- Students already in the care of community clinicians should maintain those connections.
- **Referrals must be made by a physician licensed to practice in Ontario**

We receive a large volume of referrals and there is a wait for our services. The referral review may take up to 14 days to complete**.**

CLIENT MUST BE A <u>CURRENTLY REGISTERED STUDENT</u> AT THE UNIVERSITY OF TORONTO

- **We do not provide assessments on an emergent basis**
- **We do not provide case management services**
- **We do not provide consultation for legal/insurance/workers compensation/fitness to practice/placements/disability purposes**

In order to help us provide the best care, please provide as much detail as possible, including:

- Previous psychiatric consultations or discharge summaries
- Relevant lab, test results (e.g. therapeutic drug levels) and medication summary
- Psychological reports and medical reports

Incomplete forms will be returned and will cause a delay.

If your client is in need of immediate help, please send them to the nearest emergency department or contact 911.

Please FAX completed referral form to (416) 978-7341.

If you wish to discuss your referral, please contact Client Care Coordinator at (416) 978-8078.

Client/Patient Information
Last Name:
First Name:
Date of Birth (dd/mm/yyyy):
Date of Referral (dd/mm/yyyy):

1. Please ensure you have spoken to your client / patient about the referral.
   Is your client/patient aware of this referral?
   ☐ Yes ☐ No - If no, explain:

2. Please indicate your client/s patient's gender (Check ONE only):
   ☐ Female ☐ Male ☐ Female to Male ☐ Male to Female ☐ Questioning
   ☐ Other ☐ Prefer not to answer

Client/Patient Contact Information
Home Phone #:
Address <u>while attending university</u>:
Cell Phone #:
City/Province:
Postal Code:
Email (U of T email preferred):
U of T Student #:
Health Card # / UHIP # / Other insurance:
Version Code:
Expiry Date (dd/mm/yyyy):

3. If you are able to advise, please confirm if confidential messages can be left at the numbers provided above: ☐ Yes ☐ No

Referral Source Information
Name (Last name, First name):
☐ I am a Physician
OHIP Billing #:
Address:
City/Province:
Postal Code:
Email:
Telephone #:
Fax #:

Family Physician Information
Name (Last name, First name):
☐ Client/patient does not have a family physician ☐ Same as above
Is the client's/patient's Family Physician aware of referral? ☐ Yes ☐ No ☐ Unknown ☐ If unaware please explain:
OHIP Billing #:
Address:
City/Province:
Postal Code:
Email:
Telephone #:
Fax #:

4. Is client's/patient's current psychiatrist aware of referral?

   ☐ Yes ☐ No ☐ Unknown ☐ Does not have a psychiatrist

   If Yes, Name of Psychiatrist (Last name, First name):

   _____

5. Is client's/patient's current psychologist, social worker, psychotherapist aware of referral?

   ☐ Yes ☐ No ☐ Unknown ☐ Does not have a psychotherapist/counsellor

   If Yes, Name of Clinician (Surname, Given):

   _____

6. Reason for Referral:

☐ Psychiatric Consultation (with follow-up provided by referring clinician) and/or for the purposes of (please clarify):

_____

☐ Psychiatric Consultation and brief episode of *care (longstanding history of mental health care &/or multiple prior hospital admissions may not be appropriate for a brief model of care).

(*Note: If the student's clinical needs are beyond the clinic's scope of practice, the student will be referred back to the referring provider.)

7. Current symptoms:

8. Previous psychiatric/mental health history/psychological care:

9. Agencies, hospitals or therapies involved within the <u>past TWO years</u>:

Agency/hospital/therapy	**Date** (dd/mm/yyyy)

10. Substance Use (current substances/drugs/alcohol, amount, frequency of use):

Substance/drug/alcohol	**Amount**	**Frequency of use**

11. Risk Issues:

Risk Issue:	Please Check:	If yes, when?	Please provide details:
Suicidal ideation	☐ Yes ☐ No		
Suicide attempts	☐ Yes ☐ No		
Self-harm	☐ Yes ☐ No		
Violent behaviour	☐ Yes ☐ No		
Legal involvement	☐ Yes ☐ No		

12. Medications (psychiatric and non-psychiatric):

Medication	Current/Past	Dose/ Frequency	Response/Adverse Effects
	☐ Current ☐ Past		
	☐ Current ☐ Past		
	☐ Current ☐ Past		
	☐ Current ☐ Past		

13. Relevant Medical/Developmental History, e.g. medical conditions, academic accommodations, neurodevelopmental history, history of trauma or abuse

14. Referral Completed by:

_____ _____ _____

Print Name & Credentials Signature Date (DD/MM/YYYY)

HEALTH & WELLNESS CENTRE MEDICAL RELEASE FORM

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO UNIVERSITY OF TORONTO HEALTH & WELLNESS CENTRE

Referring clinician name, credential: _____

Phone: _____ **Fax**: _____

Address: _____

RE:

Affix CLIENT / PATIENT LABEL HERE or write Client's Lastname, Firstname, U of T Student #, DOB

The above named patient has been referred to our clinic and has requested that you transfer information from their health records to us. Below is the necessary written authorization for this release.

I hereby authorize the release of information from the health records of the above-named to:

Health & Wellness Centre, UTSG (St. George campus), University of Toronto
700 Bay Street, Suite# 1200, Toronto, ON M5G 1Z6
Tel: 416-978-8030, press option #5 Fax: 416-978-7341
Attention: Client Care Coordinators

The information requested to be released is:

Psychiatric/Psychological Reports ☐ Summary Reports ☐
Discharge Notes ☐
Psychotherapeutic reports/summary ☐
Other _____

***Any costs for this are at the expense of the patient. This release is valid for six (6) months from the date of request.**

I hereby waive any and all claims against the said Health and Wellness Centre, its clinicians, employees and agents for all purposes whatsoever in connection with the said communication and disclosure of information in the said record.

This information must contain the original signature of the patient, or the legal representative if the patient is deceased or has been declared mentally incompetent provided proof of executorship is supplied.

Client / Patient Signature: _____

Print Name: _____

Date: _____
(DD/MM/YYYY)

Witness Signature: _____

Print Name: _____

Relationship to patient: _____

Date: _____
(DD/MM/YYYY)

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