REFERRAL FORM

214 College Street, 1ST & 2ND FLOOR, Toronto, Ontario, M5T 2Z9
(416) 978-8030 • FAX (416) 978-7341

Please note:
- We provide brief, episodic care to help students meet their academic goals, returning them to community care as appropriate
- We offer Psychiatric Consultations and brief episodes of care
- Students already in the care of community clinicians should maintain those connections

We receive a large volume of referrals and there is a wait for our services. The referral review may take 2 to 3 weeks to complete. Until the referral is accepted, you are responsible for the medical and mental health care of your patient.

CLIENT MUST BE A CURRENTLY REGISTERED STUDENT 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.
**HEALTH & WELLNESS CENTRE REFERRAL FORM**

<table>
<thead>
<tr>
<th>Client/Patient Information</th>
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</thead>
<tbody>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Date of Birth (dd/mm/yyyy):</td>
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<tr>
<td>Date of Referral (dd/mm/yyyy):</td>
</tr>
</tbody>
</table>

Please ensure you have spoken to your client / patient about the referral.

1. Is your client/patient aware of this referral?
   - ☐ Yes
   - ☐ No - If no, explain:

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

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

2. 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):

Select One: Family Physician  Psychiatrist  Nurse Practitioner  Other:

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

OHIP Billing #:

Address:

City/Province:

Postal Code:

Email:

Telephone #:

Fax #:

3. 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):

__________________________________________________________

4. Is client’s/patient’s current psychotherapist/counsellor aware of referral?

Yes  No  Unknown  Does not have a psychotherapist/counsellor

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

__________________________________________________________
5. Reason for Referral:
   - ☐ Diagnostic Clarification / Psychiatric Consult
   - ☐ Medication Review
   - ☐ Suitability assessment for brief care, e.g. workshop, group

6. Current symptoms:

7. Previous psychiatric/mental health history:

8. Agencies, hospitals or therapies involved within the past TWO years:

<table>
<thead>
<tr>
<th>Agency/hospital/therapy</th>
<th>Date (dd/mm/yyyy)</th>
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9. Substance Use (current substances/drugs/alcohol, amount, frequency of use):

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<thead>
<tr>
<th>Substance/drug/alcohol</th>
<th>Amount</th>
<th>Frequency of use</th>
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10. Risk Issues:

<table>
<thead>
<tr>
<th>Risk Issue</th>
<th>Please Check</th>
<th>If yes, when?</th>
<th>Please provide details</th>
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<tbody>
<tr>
<td>Suicidal ideation</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
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<tr>
<td>Suicide attempts</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>Self-harm</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>Violent behaviour</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>Legal involvement</td>
<td>☐ Yes ☐ No</td>
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11. Medications (psychiatric and non-psychiatric):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Current/Past</th>
<th>Dose/Frequency</th>
<th>Response/Adverse Effects</th>
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<tbody>
<tr>
<td></td>
<td>☐ Current ☐ Past</td>
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<td>☐ Current ☐ Past</td>
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12. Relevant Medical/Developmental History, e.g. medical conditions, academic accommodations, neurodevelopmental history, history of trauma or abuse

13. Referral Completed by:

_____________________________ _______________________ ____________________
Print Name & Credentials Signature Date
HEALTH & WELLNESS CENTRE MEDICAL RELEASE FORM

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

To: _______________________________ Phone: ________________

______________________________________________________________________ Fax: ________________

RE: PLACE 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:

Dr. Andrea Levinson, Psychiatrist-in-Chief
Health & Wellness Centre, University of Toronto
214 College Street, Room 111, Toronto, ON M5T 2Z9
Tel: 416-978-8034 Fax: 416-978-7341
Attention: Client Care Coordinators

The information requested to be released is:

Psychiatric/Psychological Reports _______ Summary Reports _______
Discharge Notes ________
Other ______________________________________________________

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

I hereby waive any and all claims against the said Health and Wellness Centre, its physicians,
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.