Ryerson University

Medical Centre
Student Wellbeing

Ryerson Medical Centre Patient Referral Form

Information for referring physicians

- Psychiatric services at the Ryerson Medical Centre work in a shared care model with collaboration between the psychiatrist and the primary care provider.
- We provide time limited episodic psychiatric care.
- Ongoing care will be transferred back to the referring physician when deemed appropriate.
- Ryerson Medical Centre does not provide assessments on an urgent basis.
- If this referral is coming from a hospital inpatient unit, please have the community primary care physician involved in the referral process.
- If this is a referral from out of province, please have the patient first connect to a primary care physician in the province of Ontario for the referral process. We readily have primary care available at the Ryerson Medical Centre for students.
- Referring MDs remain responsible for the patient's care until the patient has been assessed by psychiatry, at which point a collaborative approach of care will be the model going forward.

How to submit a referral

- To submit a completed referral, please **fax Ryerson Medical Centre at: 416-979-5073**.
- Ryerson Medical Centre will notify the referring physician to confirm receipt of referral.

Next Steps

- If you have any questions about the referral process, please contact the Ryerson Medical Centre at **medicalct@ryerson.ca** or **416-979-5070**.

If immediate care is needed please go to the nearest emergency department or call 911*

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Date of referral:

Patient Information		
Legal Name: First Name:	Last Name:	Preferred Name: Preferred Pronouns:
Date of Birth:		Gender:
Phone Number:	Email:	
Address: City:	Province:	Postal Code:
Health Card Information Health Card #:	Version Code:	
Expiration Date:		
Are there any accessibility considerations? If so, please indicate:		

Referring Provider Information		
Name: First Name:	Last Name:	Billing Number:
Phone Number:	Email:	
Fax Number:		

Address:

City: Province: Postal Code:

Does the patient currently have a psychiatrist? ☐ Yes ☐ No
If yes, please provide their name:

First Name: Last Name:

Agencies/Hospitals involved in care in the past two years:

Referral Information

Reason for referral:

Medical History

Significant medical/psychiatric history:	How long have you seen this patient for:

Substance Use:	Allergies:

Risk and Safety Concerns				
Risk	**Yes**	**No**	**When (DD/MM/YY)**	**Details**
Suicide Ideation/Attempt	☐	☐		
Deliberate Self-harm	☐	☐		
Violent behaviour/Safety concerns	☐	☐		

Medications				
Medication	**Current**	**Dose**	**Frequency**	**Response/Effects**
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			