North Bay Regional Health Centre | Centre régional de santé de North Bay

In Parntership with

Canadian Mental Health Association North Bay and District | Association canadienne pour la santé mentale North Bay et District

Canadian Mental Health Association Cochrane-Timiskaming Addiction and Mental Health Services | Association canadienne pour la santé mentale Cochrane-Timiskaming Services de toxicomanie et de santé mentale

Developmental Disabilities Service
Physician/Primary Health Care Provider (PHCP) Referral Form

The Developmental Disabilities Service does not diagnose autism spectrum disorders or provide IQ testing or complete capacity assessments.

Client's Name: _____ DOB_____
(Last/First) (dd/mm/yy)

Gender:

❑ Male ❑ Female ❑ Trans Female ❑ Trans Male ❑ Prefer not to say ❑ Other (specify)_____

Address: _____
(street) (city) (postal code)

❑ Lives independently ❑ Lives with family or other informal supports ❑ Lives in Group home

Phone #: (____)_____ OHIP #:_____ Version Code:_____

Primary Caregiver Contact Information:

Name:_____ Relationship to client:_____
Address: _____ Preferred Phone#: (___)_____

Is patient aware of referral? ❑ Yes ❑ No
Is the client capable to consent to treatment: ❑ Yes ❑ No
If not, who makes decisions for the client:_____ Phone # :(___)_____

In order to help us provide the best care, please include the following (if possible):

- ❑**Client profile
- ❑Relevant lab and test results
- ❑Previous psychiatric consultations or discharge summaries
- ❑Medical Reports

Reason for Referral:

- ❑ Diagnostic Clarification
- ❑ Treatment Recommendation
- ❑ Medication Review
- ❑ Currently Hospitalized
- ❑ Recent Changes in Mental Health Status
- ❑ Long Standing Mental Health Challenges
- ❑ Imminent Risk to Self and Others
- ❑ Frequent Use of Emergency Department
- ❑ Frequent Use of Police Services

Please describe your clinical questions as specifically as possible:

_____
_____
_____

Diagnosis of Intellectual Disability:

Age of onset and severity of Intellectual Disability:_____
Diagnosis provided by:_____

❑ Psychological Assessment Attached ❑ No Documentation on File

Health History (*Attach most recent lab work, include abnormal blood work, and any imaging reports to speed up the processing of this referral)

Any history of:	Yes	No	If yes, date & description
Seizure Disorder	❑	❑	_____
Dementia	❑	❑	_____
Neurological (Tourette's, head injury)	❑	❑	_____
Cardiovascular	❑	❑	_____
Respiratory Conditions (COPD, asthma)	❑	❑	_____
GI (Constipation)	❑	❑	_____
Genitourinary	❑	❑	_____
Dermatological	❑	❑	_____
Endocrine (Thyroid, Diabetes, Cirrhosis)	❑	❑	_____
Hypertension	❑	❑	_____
Impaired Vision	❑	❑	_____
Impaired Hearing	❑	❑	_____
Dental	❑	❑	_____
Genetic	❑	❑	_____
Past Reportable Diseases (Hep, HIV)	❑	❑	_____
Risks (self abuse, suicide attempt, legal, homeless)	❑	❑	_____
Substance use	❑	❑	_____
Cancer	❑	❑	_____
Sleep Problems (insomnia, sleep apnea)	❑	❑	_____
High Cholesterol	❑	❑	_____
Pregnancy	❑	❑	_____
Other (please describe) _____	❑	❑	_____

Allergies/adverse reactions: _____

Past Psychotropic Medications:

Drug Name	Dose/ Time(s) Taken	Date Started	Date Discontinued	Reason for Discontinuation	Was it Beneficial?
					❑Yes ❑ No ❑ Unknown
					❑Yes ❑ No ❑ Unknown
					❑Yes ❑ No ❑ Unknown
					❑Yes ❑ No ❑ Unknown
					❑Yes ❑ No ❑ Unknown

Pharmacy: _____ Phone #: (___)_____ Fax#: (___)_____

** Primary Care of Adults with Developmental Disabilities Canadian Consensus Guidelines are available for reference @ http://www.cfp.ca/content/57/5/541.full

PHCP:_____Phone #: (___)_____ Fax#: (___)_____

Mailing Address:_____ Email address:_____

Provider signature:_____ Billing #:_____ Date Completed: _____

Please return to:

☐ DDS Clinician
CMHA, Cochrane Timiskaming
330 Second Ave., Suite 201
Timmins, ON P1N 8A4
705-267-8100 ex.2306
705-267-8202 Fax

☐ DDS Clinician
CMHA, Cochrane Timiskaming
22 May Street South
New Liskeard, ON, P0J 1P0
705-647-4444 ex.3355
705-647-4434 Fax

☐ DDS Clinician
CMHA, North Bay and District
176A Main Street West
North Bay, ON, P1B 2T5
705-495-5425
705-494-3189 Fax