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**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) \_\_\_\_\_\_\_\_\_\_

❑ 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#: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

❑\*\***Client profile** from EMR

❑Relevant lab and test results

❑Previous psychiatric consultations or discharge summaries from outside NBRHC

**Reason for Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Health History** **Yes No**Seizure Disorder ❑ ❑Dementia ❑ ❑ Neurological (Tourette’s, head injury) ❑ ❑ Cardiovascular ❑ ❑Respiratory Conditions (COPD, asthma) ❑ ❑GI (e.g. Constipation, IBS) ❑ ❑Genitourinary ❑ ❑Dermatological ❑ ❑Endocrine (Thyroid, Diabetes, Cirrhosis) ❑ ❑Hypertension ❑ ❑Impaired Vision ❑ ❑ |  **Yes No**Dental ❑ ❑Genetic ❑ ❑Past Reportable Diseases (Hep, HIV) ❑ ❑Substance use ❑ ❑Cancer ❑ ❑Sleep Problems (insomnia, sleep apnea) ❑ ❑ High Cholesterol ❑ ❑Pregnancy ❑ ❑Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Allergies/adverse reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Pharmacy: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing #:\_\_\_\_\_\_\_\_\_\_ Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return to: Fax (705) 494-3189**