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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**