Canadian Mental Health Association
Association canadienne pour la santé mentale
Cochrane-Timiskaming

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

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

☐ Referral
☐ Re-Referral (Please complete Section A and B only and attach note including any new pertinent information)

Please include any clinical information you may have. Incomplete forms will NOT delay the referral process.

A.

PHCP Name: _____ PHCP Phone #: (___)_____

Mailing address: _____ Fax #: (___)_____

B.

Patient's Name: _____ DOB_____ ☐ Male ☐ Female
(Last/First) (y/m/d)

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

Phone #.: (_____)_____ Health Card #:_____

Emergency Contact Name/relationship: _____ Phone#: (___)_____

Is patient aware of referral? ☐ Yes ☐ No
Has a formal assessment and declaration of permanent incapacity, a process during which a POA (or PGT) becomes the official SDM, been completed? ❑ Yes ❑ No ❑ Unknown
Is the patient capable to consent to treatment? ☐ Yes ☐ No ☐ Unknown
If No, Substitute Decision Maker is: _____ SDM Phone #:(___)_____

Chief Complaint/Reason for Psychiatric Assessment: _____
_____
_____
When did symptoms begin? _____
Describe symptoms when unwell?_____
_____
Any aggravating factors? _____
_____
Alleviating factors? _____

Psychiatric History
Current psychiatric involvement? ☐ Yes ☐ No Psychiatrist's Name: _____
Current psychiatric diagnosis: _____

Date	Past Diagnosed Mental Illness(es)	Doctor

Degree of Developmental Disability: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
Has a psychometric assessment been completed? (IQ testing) ❑ Yes ❑ No *If Yes, please include report if able

1. Is patient able to describe symptoms? ☐ Yes ☐ No ☐ Some
2. Does patient have understanding of diagnosis? ☐ Yes ☐ No ☐ Some
3. Does patient understand his/her intervention(s)? ☐ Yes ☐ No ☐ Some

How does patient describe any of above 3 questions? _____

_____

Has patient visited the ER in the past year? ☐ Yes ☐ No If yes, please list _____

_____

Past Psychiatric Hospitalizations (attach sheet if needed)

Facility	Admission Date	Discharge Date	Reason	Diagnosis

Past Medical/Surgical Hospitalizations (including pregnancies)

Facility	Admission Date	Discharge Date	Reason	Diagnosis

Health History (*Attach most recent labwork, 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 (Alzheimer's, Lewy body, Frontal lobe)	☐	☐	_____
Neurological Problems (Tourette's, head injury)	☐	☐	_____
Cardiovascular Conditions	☐	☐	_____
Respiratory Conditions (sleep apnea, asthma)	☐	☐	_____
GI Complications (GERD, H Pylori)	☐	☐	_____
Genitourinary Conditions	☐	☐	_____
Skin Conditions	☐	☐	_____
Musculoskeletal Conditions (Scoliosis)	☐	☐	_____
Endocrine (Thyroid, Diabetes, Cirrhosis)	☐	☐	_____
Hypertension	☐	☐	_____
Impaired Vision	☐	☐	_____
Impaired Hearing	☐	☐	_____
Dental Problems	☐	☐	_____
Genetic Conditions	☐	☐	_____
Past Reportable Diseases (Hep, HIV)	☐	☐	_____
Risks (self abuse, suicide attempt, legal, homeless)	☐	☐	_____
Drug Use (alcohol, tobacco, cannabis, caffeine)	☐	☐	_____
Cancer	☐	☐	_____
Sleep Problems (insomnia)	☐	☐	_____
High Cholesterol	☐	☐	_____
Pregnancy	☐	☐	_____
Other (please describe) _____	☐	☐	_____

Medication Contraindications: _____

Height: _____Weight (+ date taken):_____BP_____ Allergies: _____

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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

Current Medications: *Attach extra sheet if necessary

Including any prn/over-the counter/herbal/supplements the patient takes. ***Provide a print out from the pharmacy if easier/able.***

Drug Name	Dose/ time(s) Taken	Date Started	Is it Beneficial?	List any side effects noted by patient/ care provider
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	
			☐Yes ☐ No ☐ Unknown	

Pharmacy: _____ Phone No:_____

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

Completed by (if other than family physician):_____ Date Completed: _____

Please Fax/Send to:

Lynne Marwick
Mental Health & Addictions Clinician
Developmental Disabilities Service
In Partnership with
CMHA Cochrane Timiskaming Branch
20 May Street South
New Liskeard, Ontario, P0J 1P0
Phone: 705-647-4444 Ext. 3356
Fax: 705-647-4434