  

**Physician Referral Form**

**Dual Diagnosis Collaborative Consultation Program**

**Tel: 705-748-6687 ext. 1045 Fax: 705-748-5649**

**E-mail: DDCCP@cmhahkpr.ca**

**Patient Information:**

|  |  |  |
| --- | --- | --- |
| Patient Name  (please print) |  | |
| Address |  | |
| City, Postal Code |  | |
| Telephone |  | |
| Health Card # |  | VC: |
| DOB (D-M-Y) |  | |

**Supports:**

|  |  |
| --- | --- |
| Next of Kin Name |  |
| Address |  |
| City, Postal Code |  |
| Telephone |  |
| Relationship |  |
| Group Home |  |
| Contact Name |  |
| Telephone |  |

**Collateral Information:**

|  |  |
| --- | --- |
| **Please attach:** | **check ☑ all that apply** |
| Proof of diagnosis | Yes  No |
| Recent medication list | Yes  No |
| Recent bloodwork | Yes  No |
| Patient history | Yes  No |
| Psychological assessments | Yes  No |

**Reason for Referral:**

**Diagnosis (check ☑ all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| **🗆** | Intellectual Disability | **🗆** | Learning Disability |
| **🗆** | Developmental Delay | **🗆** | Any other diagnosis ( elaborate below) |
| **🗆** | FASD | **🗆** | Autism Spectrum Disorder |

  

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| --- |
| **Please state reason for referral/ referral question**  What is the referring question? What do you hope to gain from this referral to D.D.C.C.P.?  **Current Supports:**  What supports does the patient have in place? ( formal and informal) What do these supports do for the patient? |

|  |  |  |
| --- | --- | --- |
| Physician Signature | | Address |
| Name ( please print ) | | Date |
| Tel: | Fax: | Physician Billing # |