DDCP REFERRAL FORM

CONFIDENTIAL

Developmental Disabilities Consulting Program
Tel: 343-477-0285 Fax: 613-548-0404

Patient Information:		**Primary Contact Information:**	
Patient Name		Contact Name:	
Street Address		Telephone	
City, Postal Code		Email	
Telephone		Relationship:	☐ Parent/Guardian ☐ SDM ☐ Other: _____ (please specify)
Health Card #	VC:		
Date of Birth (DD-MM-YY)			
Sex ☐ M ☐ F ☐ Prefer not to disclose		Gender: _____	

Reason for Referral (check all that apply or provide details below):	
☐ Functional decline	☐ Academic performance
☐ Challenging behaviour (aggression, self-injury, sexual)	☐ Adjustment/grief
☐ Family/Caregiver issues	☐ Mood
Describe:	
Please list diagnoses:	

Please specify the type of service needed (check all that apply):

Please note additional documentation requirements associated with certain services (outlined below) and attach forms as indicated. Referrals with missing documentation will be returned

☐ **Psychiatry** (Physician referral only)	☐ **Psychology** (Fee for service only)	☐ **Occupational Therapy** (Fee for service only)
☐ **Consultation** (Psychiatric/ behavioural concerns; medication review) **Confirmation of ID diagnosis required for ongoing psychiatric care; single consult offered for those with confirmed ASD only. **Please attach the following information: medication list, lab reports, medical history, neuroimaging, specialist reports.	☐ **Diagnostic Assessment** (ID, ASD, mental health, educational, sexual/risk) ☐ **Individual Psychotherapy** ☐ **Family/Caregiver Therapy** ☐ **Consultation**	☐ **Assessment** (functional/independent living, self-care, sensory processing, vocational, leisure) ☐ **Individual Therapy** (skill development, promoting participation/ independence) ☐ **Family/Caregiver Support** ☐ **Consultation**

Referrer Name (print):	Referrer Signature:	Date of Referral:
Physician Billing # (if applicable):	Tel:	Email: