DDCP REFERRAL FORM

Developmental Disabilities Consulting Program
817 Division Street, Kingston, ON, K7K 4C2
Tel: 343-477-0285 Fax: 613-548-0404

Patient Name			Next of Kin Name	
Address			Address	
City, Postal Code			City, Postal Code	
Telephone			Telephone	
Health Card #		VC:		
DOB (D-M-Y)				
Gender	M ☐ F ☐			

Reason for Referral

Additional Concerns (check ✓ all that apply)			
☐	Unknown Cause of intellectual disability	☐	Sleep disturbance
☐	Medication Review	☐	Lethargy/weakness
☐	Speech Language pathology Assessment	☐	Weight loss/gain
☐	Genetic Assessment	☐	Mobility problems/spasticity
☐	Physical Health Concerns	☐	Swallowing concern
☐	Functional decline	☐	Constipation/GERD/other G.I.
☐	Other, please specify		

Mental Health Concerns (check ✓ all that apply)			
☐	Behavioural disorder	☐	Adjustment/grief reaction
☐	Mood or psychotic disorder	☐	Family/Caregiver Issue

Please attach the following information if available: **Medication List, Past Medical History, Neuroimaging or Laboratory Reports, Specialist Reports**		
Referrer Signature		
Name (please print)	Tel:	Email:
Physician Billing # (if applicable)	Date	