

## DDCP REFERRAL FORM

Developmental Disabilities Consulting Program  
 191 Portsmouth Avenue, Kingston, ON  
 Tel: 613-549-7944 Fax: 613-549-7387



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 <input type="checkbox"/> F <input type="checkbox"/>		

<b>Reason for Referral</b>

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

<b>Mental Health Concerns (check ✓ all that apply)</b>			
<input type="checkbox"/>	Behavioural disorder	<input type="checkbox"/>	Adjustment/grief reaction
<input type="checkbox"/>	Mood or psychotic disorder	<input type="checkbox"/>	Family/Caregiver Issue

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