**Referral for Medical Consultation**

**Please select a clinic below**

[ ] Family Medicine IDD Consultation Clinic [ ]  Adult IDD Psychiatry Clinic

[ ]  Developmental Pediatrics [ ]  Child IDD Psychiatry Clinic

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| REFERRING PHYSICIAN INFORMATION |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Billing #: \_\_\_\_\_\_\_\_\_\_\_ | Signature:­­­ ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PATIENT INFORMATION |
| Please fill out the following patient contact information: |
| Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dd/mm/yyyy) | OHIP #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Version Code:  \_\_\_\_\_\_\_\_\_ |
| Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason for referral:  |
| Please provide the reason for referral: |
| Diagnosis: Please provide the patients diagnosis: |
|  |
| Medication:  | Please provide the following if available:  |
| Please list any medications: | * Previous (relevant) medical, genetic, and psychiatric assessment reports
* Previous psychology assessment reports
* Updated medication list
* Recent investigations (bloodwork, imagining, etc.)
* Recent and/or relevant discharge summaries or specialist consult notes (past 2 years)
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**Please fax to Surrey Place Medical Services 416-929-8199.**

**Questions/concerns please call: 416-925-5141 ext. 2582**