



Better health. Best in health care.

Developmental Disabilities Mental Health Services

Primary Health Care Provider Information Form

This form will only be accepted if filled out by the Primary Care Provider (i.e. GP/Family Physician).

DDMHS provides short-term specialized mental health services to individuals who live with co-occurring developmental disabilities and mental illness and/or challenging behaviours. Our assessment process requires that clients be medically assessed to rule out potential underlying conditions that may contribute to their presentation. We appreciate your ongoing collaboration as an equal member of the treatment team.

CLIENT INFORMATION:	
Surname:	Given Name(s): PHN: DOB (dd/mm/yy):
SUMMARY OF CONCERNS: *(Please attach any available history or assessments)	
Presenting Problems: (please describe the current symptoms of mental illness. Include substance use, suicide risk, and risk of aggression)	
Services Requested/Desired Outcome:	
Current Medications: (including over the counter, herbals, and vitamins) *Attach if multiple	
Medication Adherence: <input type="checkbox"/> Not an issue <input type="checkbox"/> Unknown <input type="checkbox"/> Compliance Issues (please specify)	
Medical Conditions (including allergies):	
Date of Last Physical Examination:	
Please complete and attach current (within 3 months) Lab Results: <input type="checkbox"/> Liver & Kidney function <input type="checkbox"/> CBC & Electrolytes <input type="checkbox"/> Thyroid (TSH) <input type="checkbox"/> B12 <input type="checkbox"/> Ferritin <input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Lipid Panel <input type="checkbox"/> Therapeutic Drug Levels (_____) <input type="checkbox"/> Hormone Levels (For women over 30, if concerns) <input type="checkbox"/> H.Pylori testing	Please attach the following reports if available: Imaging Reports: <input type="checkbox"/> CT Head <input type="checkbox"/> EEG <input type="checkbox"/> ECG <input type="checkbox"/> MRI Head Relevant Consultations: <input type="checkbox"/> Neurology <input type="checkbox"/> Psychiatric/Mental Health <input type="checkbox"/> Psychology <input type="checkbox"/> Other Medical Doctor/NP Name: (print or stamp): MSP Number: Signature:
Send Completed Form to:	
L50 – 4946 Canada Way, Burnaby, BC, V5G 4H7 TEL: (604) 918-7540 FAX: (604) 918-7550	Burnaby, New Westminster, Tri-Cities, Maple Ridge, Vancouver, Richmond, North Shore to Pemberton & the Sunshine Coast
#207 – 2248 Elgin Ave, Port Coquitlam, BC, V3C 2B2 TEL: (604) 777-8475 FAX: (604) 461-2189	Abbotsford, Agassiz, Chilliwack, Hope, Mission, Langley Delta, Surrey, White Rock, Tsawwassen, Ladner, Aldergrove