nova scotia health authority

COAST Team Referral Form

Tel: 902-464-6025
Fax: 902-464-3044

Physician Referral Form

Patient Name: _____ Address: _____

Postal Code: _____ Phone: _____

Date of birth: _____ Gender: _____ HCN: _____

Family physician name: _____ Phone: _____ Fax: _____

Contact person: _____ Phone: _____

Date Completed: _____

Level of Intellectual functioning: □ Borderline Intellectual Disability (MR) □ Mild Intellectual Disability (MR) □ Moderate Intellectual Disability (MR) □ Severe Intellectual Disability (MR) □ Profound Intellectual Disability (MR)

Brief description of the problem presented to you (please include symptoms, level of distress **and** impact on day to day life and strategies done to address the issue): _____

Name: _____

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Medications (current) and Allergies/sensitivities:

_____
_____
_____
_____
_____
_____

Past Medications:

_____
_____
_____
_____
_____

Past Psychiatric History:

_____
_____
_____
_____

Medical History:

_____
_____
_____
_____
_____
_____

History of Seizures: □Y or □ N Problem with: □ Vision □ Hearing □ Dental

Has the patient had a physical examination in the last 6 months? □ Y or □ N If yes please provide a report.

Has the patient had a □ CT □ MRI □ EEG? If yes, please attach

*****Please complete (and attach) the following blood work: Urinalysis, CBC, electrolytes, liver and kidney function tests, TSH and mood stabilizer/antiepileptic drug levels*****

Please fax this completed form to 902-464-3044