CENTRAL WEST SPECIALIZED DEVELOPMENTAL SERVICES
Accredited Organization 2012 - 2016 FOCUS accreditation

DUAL DIAGNOSIS SERVICE

53 Bond Street, Oakville, Ontario L6K 1L8
P: 905-844-7864 F: 905-849-0192

DUAL DIAGNOSIS SERVICE REFERRAL

Please fax this referral, endorsed with the signature of the Lead Agency Director or Agency Designate to:
Fax – 905-849-0192
If you require assistance, please contact the intake resource worker at – 905-844-7864 Ext. 315

_____ _____
Lead Agency Director or Agency Designate **Date**

All persons referred must be deemed eligible for adult services through Developmental Services Ontario (DSO). Referrals can be initiated by the person, family members, community agencies and practitioners. H**owever, all referrals must be made with the support of the manager/ service coordinator and director or designate of the lead agency, the person is affiliated with.**

If you are not registered with the DSO and/or do not have a service coordinator assigned, please contact the DSO office in your region:

Toll free: 1-888-941-1121 **Waterloo:** 519-741-1121 **Peel**: (905) 453-2747 ext.2501
Dufferin/Wellington: 519-821-5716 **Halton:** 905-876-1373

The Dual Diagnosis Service (DDS) is a tertiary level service. The service offers assessments and treatment planning for persons who have a developmental disability, and behavioural and/or mental health concerns that have been diagnosed or queried.

The DDS team assists the family/caregivers in implementing the treatment plan. The team does not offer front line services, ongoing psychiatric support or health care and is not a crisis service. The team does not provide residential placement.

In order to provide you, your family and/or caregivers, with a full and valid assessment, and a comprehensive treatment plan, the DDS Team requires the referral package to be as accurate and complete as possible.

We request that when a person is residing in an agency residential home or within a supported independent living environment that both the person's primary worker and the supervisor attend the psychiatric/psychological consults at DDS. If the person referred resides with family members and/or continues to maintain close family contact, the family member is also requested to attend the psychiatric/psychological consults. Please do not send a driver or staff member who is unfamiliar with the referred person's history and current status.

_____ _____
Signature of Person/ Substitute Decision Maker Signature of Manager /Service Coordinator

_____ _____
Print Name and Relationship (if other than person) Print Name of Manager /Service Coordinator

_____ _____
Date Date

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Please confirm the following Dual Diagnosis Service referral criteria is met:

- ☐ The person has been confirmed eligible for adult services through the DSO
- ☐ The person is 18 years of age or older
- ☐ The person resides within the Central West Region
- ☐ The person has a diagnosed developmental disability
- ☐ The person has a diagnosed or suspected mental illness
- ☐ The person has had a physical within the last 12 months Date:_____
- ☐ The person has had routine blood work within the last 6 months Date:_____
- ☐ The person has a service coordinator and/or case manager actively involved
- ☐ All community supports have been exhausted
- ☐ The person's needs exceed the existing available community resources. Please describe.

_____
_____
_____
_____

Please provide detailed information on the presenting issues requiring Dual Diagnosis Service involvement: (continue on the back of this form if necessary)

_____
_____
_____
_____
_____

Please indicate the documentation available from past and/or current involvement and <u>include with this referral package:</u>

- ☐ Summary of service coordination involvement Date and Location:_____
- ☐ Psychiatric assessment(s) and/or test results, recommendations or treatment plan(s) Date and Location:_____
- ☐ List of current medication(s) Date and Location:_____
- ☐ Psychological report(s) and/or test result(s) Date and Location:_____
- ☐ Behavioural assessment(s), program(s) and/or protocol(s) Date and Location:_____
- ☐ Summary of medical history and/or test(s) results including medication history Date and Location:_____
- ☐ Hospital discharge summaries
- ☐ Speech-language report(s) and/or treatment plan(s) Date and Location:_____
- ☐ Occupational therapy report(s) and/or treatment plan(s) Date and Location:_____
- ☐ Physiotherapy report(s) and/or treatment plan(s) Date and Location:_____
- ☐ School assessment report(s) Date and Location:_____
- ☐ Vocational and/or day service involvement Date and Location:_____
- ☐ Other:_____

_____

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The Referred Person	
LAST FIRST Name:	DAY MONTH YEAR D.O.B.:
Address:	
Telephone:	Health Card #:

Next of Kin or Substitute Decision Maker	
Name:	Relationship:
Address:	
Telephone:	Email:
Next of Kin or Substitute Decision Maker	
Name:	Relationship:
Address:	
Telephone:	Email:

Person Providing Consent to This Referral	
Name:	Relationship:

Referring Agency (if applicable)	
Agency Name:	County/Region:
Contact Person:	Position:
Address:	
Telephone:	Fax:
Email:	

Service Coordinator (if different from above)	
Name:	Agency Name:
Address:	
Telephone:	Fax:
Email:	

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Residential Supervisor/Key Contact (if not at home)	
Group Home:	Contact Person:
Address:	
Telephone:	Fax:
Email:	
Day Services / School Supervisor/Key Contact	
Day Program:	Contact Person:
Address:	
Telephone:	Fax:
Email:	
Pharmacy (Currently Used)	
Name:	
Address:	
Phone:	Fax:
Family Physician	
Name:	
Address:	
Phone:	Fax:
Community Psychiatrist	
Name:	
Address:	
Phone:	Fax:
Neurologist	
Name:	
Address:	
Phone:	Fax:

cc: Psychiatrist / Psychologist
Clinical Director
Intake Resource Worker
Main File