

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. However, 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 Dufferin/Wellington: 519-821-5716 Waterloo: 519-741-1121 Halton: 905-876-1373 Peel: (905) 453-2747 ext.2501

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

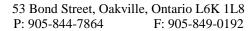
Signature of Manager /Service Coordinator

Print Name and Relationship (if other than person)

Print Name of Manager /Service Coordinator

Date

Date



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

FOCUS

- □ The person has been confirmed eligible for adult services through the DSO
- □ The person is 18 years of age or older

CENTRAL WEST

SPECIALIZED DEVELOPMENTAL

SERVICES /

Accredited Organization 2012 - 2016

- □ 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</u> package:

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		DAY	MONTH	YEAR
Name:		D.O.B.:			
Address:					
Telephone:		Health Card	l #:		
Next of Kin or Substitute Decision Maker					
Name:		Relationship	o:		
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