**DUAL DIAGNOSIS SERVICE REFERRAL**

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

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****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. The referral must be approved and signed off by the Lead Agency Director or Agency Designate.**

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 tertiarylevel service. The serviceoffers 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.

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

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

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Date Date

**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.

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

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**Please indicate the documentation available from past and/or current involvement. \*Reminder: Please include a copy of all documentation with this referral package:**

* Summary of service coordination involvement Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Developmental Services of Ontario assessment(s) 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 FIRSTName: |  DAY MONTH YEARD.O.B.: |
| Address: |
| Telephone: | Health Card #: |
| Height: | Weight: |

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

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| **Person Providing Consent to This Referral** |
| Name: | Relationship: |

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

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| **Service Coordinator** (if different from above) |
| Name: | Agency Name:  |
| Address: |
| Telephone: | Fax: |
| Email: |
| **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-Include Fax) |
| Name: |
| Address: |
| Phone: | Fax: |
| **Family Physician** (Include Address & Fax) |
| Name: |
| Address: |
| Phone: | Fax: |
| **Community Psychiatrist** (Include Address & Fax) |
| Name: |
| Address: |
| Phone: | Fax: |
| **Neurologist** (Include Address & Fax) |
| Name: |
| Address: |
| Phone: | Fax: |

cc: Psychiatrist / Psychologist

 Clinical Director

 Intake Resource Worker

 Main File