**DUAL DIAGNOSIS SERVICE REFERRAL**

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| Please send this referral, endorsed with the signature of the Lead Agency Manager/Director or Agency Designate to: toto: |
| **E:** [**intake@cwsds.ca**](mailto:intake@cwsds.ca) **or F: 905-849-0192**  **Intake – 905-844-7864 Ext. 315** |
| If you require assistance, please contact the Intake Coordinator at – 905-844-7864 Ext. 315 |

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name of Lead Agency 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 service coordinator or designate of the lead agency, the person is affiliated with. The referral must be approved and signed off by the Lead Agency Manager/Director.**

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:** 1-888-941-1121 **Peel**: 1-888-941-1121

**Dufferin/Wellington:** 1-888-941-1121 **Halton:** 905-876-1373

The Dual Diagnosis Service (DDS)is a consultative, short-term, 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 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 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 Name and Signature of Manager/Director

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 a family physician
* The person has completed their annual physical within the last 1-year Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The person has had routine blood work within the last 1-year Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The person has a service coordinator and/or case manager actively involved
* All community supports have been exhausted (i.e. referrals to community psychiatrist, behavioural supports)

**Please describe how the person’s needs exceed the existing community resources:**

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**Please provide a detailed description of the presenting concerns and outline goals specific to these areas; Psychiatry, Behaviour Therapy, Speech Language Pathology and Occupational Therapy:**

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

* Summary of service coordination involvement (if relevant) Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Developmental Services Ontario assessment(s) Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Psychiatric assessment(s)/consultation notes Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Psychological report(s)/consultation notes Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* List of current medication(s) and medication history Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hospital discharge summaries (within past 5 years) Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Behavioural assessment(s), program(s) and/or protocol(s) Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Speech-language report(s) and/or treatment plan(s) Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Occupational therapy report(s) and/or treatment plan(s) Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* School assessment report(s) /current IEP Date and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  (if relevant and available)
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **The Referred Person** | | |
| LAST FIRST  Name: | DAY MONTH YEAR  D.O.B.: | |
| Male  Female  Other: Preferred Pronoun: | | |
| Address: | | |
| Telephone: | OHIP #: | Version Code: |
| 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: | |
| **Supportive Living Supervisor/Primary Contact** (if not at home) | |
| Name of Home: | Contact Person: |
| Address: | |
| Telephone: | Fax: |
| Email: | |
| **Day Service/School Primary Contact** | |
| Name of Day Service/School: | 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: |
| Is the community psychiatrist aware of this referral and requesting a second opinion Yes  No | |
| **Neurologist** (Include Address & Fax) | |
| Name: | |
| Address: | |
| Phone: | Fax: |

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| **DEVELOPMENTAL DISORDERS** | | | | |
|  | **Diagnosed or Suspected** | | **By Whom?** | **When?** |
| Global Developmental Disability |  |  |  |  |
| Autism Spectrum Disorders |  |  |  |  |
| PDD-NOS |  |  |  |  |
| Down Syndrome |  |  |  |  |
| Fragile-X |  |  |  |  |
| Prader Willi Syndrome |  |  |  |  |
| Angelman Syndrome |  |  |  |  |
| Fetal Alcohol Syndrome / Effect |  |  |  |  |
| Williams Syndrome |  |  |  |  |
| Other: |  |  |  |  |

**PSYCHIATRIC**

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| **PSYCHIATRIC CONDITIONS AND/OR SYMPTOMS** | | | | | | | | |
|  | | | **Diagnosed or Suspected** | | **By Whom?** | | | **When?** |
| **Depression** | | |  |  |  | | |  |
|  | Crying |  | Withdrawn | | |  | Fatigue | |
|  | Lack of Interest / Motivation |  | Restless, Agitated, Irritable | | |  | Difficulty Concentrating / Focus | |
|  | Suicidal Ideation |  | Difficulty Sleeping | | |  | Change in Appetite | |
|  | Feelings Associated with Low Self-Esteem | | | | | | | |
| **Mania** | | |  |  |  | | |  |
|  | Decreased Need for Sleep |  | Restless / Agitated / Irritable | | |  | Speaks Loudly | |
|  | Elation for Unknown Reason |  | Easily Distracted | | |  | Speaks Quickly | |
| **Bipolar Disorder** | | |  |  |  | | |  |
|  | Combination of Symptoms Listed Above | | | | | | | |
| **Anxiety Disorder** | | |  |  |  | | |  |
|  | Separation |  | New Situations | | |  | Generalized | |
|  | Agitation / Irritable |  | Excessive Fear | | |  | Apprehension | |
|  | Clings to Familiar People |  | Runs Away | | |  | Cries | |
|  | Perspires |  | Breathing Becomes Heavier | | |  | Trembles / Shakes | |

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| **Psychosis / Schizophrenia** | | |  |  |  | | |  |
|  | Auditory Hallucinations |  | Visual Hallucinations | | |  | Tactile Hallucinations | |
|  | Hearing Voices |  | Delusions | | |  | Unrelated Mood | |
|  | Bizarre / Inappropriate Positions |  | Suicidal Ideation | | |  |  | |
| **Obsessive Compulsive Disorder** | | |  |  |  | | |  |
|  | Excessive Habits / Thoughts |  | Uncomfortable Thoughts | | |  | Excessive Worry | |
| **(Borderline) Personality Disorder** | | |  |  |  | | |  |
| **Mood Disorder** | | |  |  |  | | |  |
| **Oppositional Defiant Disorder** | | |  |  |  | | |  |
| **Impulse Control Disorder** | | |  |  |  | | |  |
| **Post-Traumatic Stress Disorder** | | |  |  |  | | |  |
| **ADHD / ADD** | | |  |  |  | | |  |
| **Panic Disorder** | | |  |  |  | | |  |
| **Phobias** | | |  |  |  | | |  |
| **Tourette’s / Tics** | | |  |  |  | | |  |
| **Eating Disorders** | | |  |  |  | | |  |
| **Alcohol / Drug Use** | | | Casual | Frequent |  | | |  |

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| **PSYCHIATRIC DETAILS** |
| **Psychiatric History**: Summary of previous psychiatric hospitalizations, institutionalizations, recent emergency room visits, ongoing community psychiatric treatment, etc. |
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| **Presenting Concerns**: Summary of onset of current mental health symptoms/issues. |
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| **Familial History**: Summary of psychiatric history of the family of this person. |
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| **RECENT SIGNIFICANT CHANGES** | |
|  | Change in activity levels |
|  | Change in appetite or fluid intake |
|  | Change in overall mood |
|  | Change in sleep pattern |
|  | New, unusual body movements (tremors, tics, etc.) |
|  | Increased perseveration or obsessive compulsive behaviours (difficulty shifting from idea/topic, etc.) |
|  | Marked overall increase in anxiety |
|  | Other recent changes noted |

**MEDICAL**

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| **MEDICAL CONDITIONS** | |
|  | Heart Problems / Disease (heart attack, congestive heart failure, irregular heartbeat, etc.) |
|  | Ear Infections |
|  | Sinusitis |
|  | Infectious Diseases (measles, German measles, chicken pox, meningitis, mumps, etc.) |
|  | Birth Trauma (Cerebral Palsy, jaundice, blue baby, Rh problems, etc.) |
|  | Encephalitis |
|  | High Fever |
|  | Respiratory Problems / Infections (asthma, bronchitis, pneumonia, etc.) |
|  | Diabetes |
|  | Epilepsy (convulsions) or Other Neurological Problems |
|  | Hepatitis (A, B or C) |
|  | Gastro-Intestinal Problems (Gastroesophageal Reflux Disease, ulcers, vomiting, etc.) |
|  | Bowel / Bladder Problems (diarrhea, abdominal pain, constipation, incontinence etc.) |
|  | Chronic Pain |
|  | Genetic Problems (Cystic Fibrosis, Phenylketonuria, etc.) |
|  | Hormonal Problems (menstrual cycle issues, hormone imbalance, etc.) |
|  | Head Injury / Trauma |
|  | Cleft Lip / Palate |
|  | Muscular Skeletal (spasticity, arthritis, mobility issues, etc.) |
|  | Bone / Joint Problems |
|  | Thyroid Problems |
|  | Sexually Transmitted Infections (HIV, AIDS, etc.) |
|  | Foot Problems |
|  | Skin Problems (psoriasis, eczema, etc.) |
|  | Weight Gain / Loss (over the last year) |
|  | Allergies (to prescribed medications, to over the counter medications, to foods, to environmental conditions) |
|  | Sleep Disorders (sleep apnea – CPAP required, early morning waking, difficulty getting to sleep) |
|  | Visual Impairment (corrective lenses, legally blind, etc.) |
|  | Hearing Impairment (hearing aids, conductive hearing loss, etc.) |
|  | Past Surgeries (oral, joint or bone, internal, etc.) |
|  | Yearly Physical |
|  | Routine Blood Work |
|  | Are Immunizations Up To Date:  Yes  No (Please include a copy of the immunization record) |

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| **FAMILY MEDICAL HISTORY** |
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| **CURRENT MEDICATIONS** | | | |
| **Drug Name** | **Dosage** | **Times / Day** | **Reason for Medication** |
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| **ABUSE AND TRAUMA** | | | |
| **Physical** | Known | Reported | Suspected |
| **Sexual** | Known | Reported | Suspected |
| **Emotional** | Known | Reported | Suspected |
| **Experience:** Describe the abuse or trauma experienced by the person? | | | |
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| **Witness:** Describe the abuse or trauma witnessed by the person? | | | |
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| **Children’s Aid Society (CAS):** Was the person ever placed in the care of the CAS? | | | |
| Yes  No  If so, for approximately what length of time?  If so, at what age? | | | |

**BEHAVIOUR**

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| **PHENOTYPE OF CURRENT BEHAVIOURS** | | | |
| **Physical** | | | |
|  | Hitting |  | Kicking |
|  | Pushing |  | Scratching |
|  | Spitting |  | Biting |
|  | Pinching |  | Pulling Hair |
|  | Running Away (AWOL) |  | Inappropriate Undressing |
|  | Other: | | |
| **Verbal** | | | |
|  | Yelling |  | Screaming |
|  | Swearing |  | Refusal |
|  | Other: | | |
| **Self-Injurious Behaviour** | | | |
|  | Head Banging |  | Biting Self |
|  | Picking at Self |  | Hitting Self |
|  | Other: | | |
| **Environmental** | | | |
|  | Throwing Items |  | Tearing Items |
|  | Breaking Items |  | Banging Items |
|  | Other: | | |
| **Obsessive Behaviours** | | | |
|  | Reassurance Seeking |  | Hording |
|  | Insistence on Sameness |  | Perseveration |
|  | Other: | | |

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| **DETAILS OF CURRENT BEHAVIOUR** | | | |
| **Target Behaviour** | **Location (i.e. home/school/day service)** | **Duration  (length of episodes)** | **Frequency**  **(how often do episodes occur)** |
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| **Target Behaviour** | **Intervention / Management** | **Outcome / Effectiveness** |
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| **Antecedents**: What typically triggers a behavioural incident? | | |
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| **Support Level**: What is the current level of support provided to the person? (1:1, 2:1, 1:4) | | |
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| **Change in Presentation**: Was there a change in the presentation of behavioural difficulties? (new, long standing, increase in frequency, increase in intensity) | | |
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| **Data**: Is data being collected? (ABC charts, incident reports) If yes, please provide a copy | | |
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| **LEGAL ISSUES** | | |
| **Concerns**: Please describe any historical or current legal issues, civil or criminal (Status, stage of court process, conditions). If yes, how many times has this occurred? | | |
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| Is the person deemed financially competent?  Yes  No  If not, who provides consent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the person require assistance with their finances?  Yes  No | | |

**COMMUNICATION**

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| **METHOD OF COMMUNICATION** | | | |
| **Primary Form of Expressive Communication** | | | |
|  | Single Words |  | Short Sentences |
|  | Complete Sentences |  | Signs |
|  | Gestures |  | Pictures / Picture Exchange Communication System (PECS) |
|  | Other: | | |
| **Primary Form of Receptive Communication** | | | |
|  | Single Words |  | Short Sentences |
|  | Complete Sentences |  | Signs |
|  | Gestures |  | Pictures / PECS |
|  | Other: | | |

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| **Description / Notes**: | |
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| What is the person’s first language? | Does he/she understand/use any other language? |

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| **COMMUNICATION RATING SCALE** | | | | | |
|  | **Always** | **Usually** | **Sometimes** | **Rarely** | **Never** |
| Does the person follow *routine* direction? |  |  |  |  |  |
| Does the person follow *non-routine* direction? |  |  |  |  |  |
| Does the person understand yes/no questions? |  |  |  |  |  |
| Does the person use visual aids to support their understanding? |  |  |  |  |  |
| When the person communicates, is this method understood by *familiar* communication partners (immediate support team)? |  |  |  |  |  |
| When the person communicates, is the method understood by *unfamiliar* communication partners (strangers)? |  |  |  |  |  |
| Does the person’s communication deficits create anxiety? |  |  |  |  |  |

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| **SWALLOWING ASSESSMENT** |
| Does the person experience difficulty with swallowing? (coughing, choking, throat clearing, drooling, food remaining in mouth after meal, etc.) |
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| If yes, how often does this happen? |
| If yes, how long has this been occurring? |
| If yes, is the person on any type of modified diet? (thickened fluids, puree diet, etc.) |
| Has the person ever had a swallowing assessment? |
| If yes, when did this occur? |

**OCCUPATIONAL**

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| **ACTIVITIES OF DAILY LIVING – LEVEL OF ASSISSTANCE** | | | | | |
|  | **Independent** | **Supervision** | **Prompts** | **1:1 Assistance** | **Dependent** |
| Toileting |  |  |  |  |  |
| Grooming |  |  |  |  |  |
| Dressing / Undressing |  |  |  |  |  |
| Bathing / Showering  Commode  Transfer Bars  Shower Chair  Other: |  |  |  |  |  |
| Mobility / Transfer / Stairs  Orthotics  Crutches  Walker  Wheelchair  Cane  Scooter  Other: |  |  |  |  |  |
| Eating / Drinking |  |  |  |  |  |
| Taking Medications |  |  |  |  |  |
| Attending Medical Appointments |  |  |  |  |  |
| Sleeping |  |  |  |  |  |
| Participation in Recreational Activities |  |  |  |  |  |
| Socializing with Others |  |  |  |  |  |
| Home Chores / Maintenance of Room |  |  |  |  |  |
| Meal Preparation |  |  |  |  |  |
| Laundry |  |  |  |  |  |
| Work or School |  |  |  |  |  |
| Reading / Writing |  |  |  |  |  |
| Transportation |  |  |  |  |  |
| Telephone Use |  |  |  |  |  |
| Shopping / Using Money |  |  |  |  |  |

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| **SENSORY** |
| Describe any exaggerated, subdued or inconsistent responses to sounds, touch, lights, movement, etc. the person experiences. |
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**COMMUNITY SUPPORTS**

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| **OTHER CURRENT CLINICAL INVOLVEMENT** | | | | |
|  | **Name / Level of Involvement** | **Date of Most Recent Involvement** | **Report** | |
| **Available** | **Provided** |
| Psychologist |  |  |  |  |
| Behaviour Therapist |  |  |  |  |
| Speech-Language Pathologist |  |  |  |  |
| Occupational Therapist |  |  |  |  |
| Specialized Medical Consult |  |  |  |  |
| Nurse |  |  |  |  |
| Home and Community Care Support Services |  |  |  |  |
| Social Worker |  |  |  |  |
| Counsellor |  |  |  |  |
| Other: |  |  |  |  |

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| **CURRENT COMMUNITY SUPPORTS** |
| List of agencies / community supports that are or have recently been involved with the person and his/her family. |

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| --- | --- |
| **USE OF COMMUNITY EMERGENCY SUPPORTS** | |
| Number of emergency room visits over the last year? |  |
| Number of admissions to hospital over the last year? |  |
| Number of inpatient programs accessed over the last year? |  |
| Number of 911 calls over the last year? |  |

|  |  |  |  |  |  |
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| **EDUCATIONAL HISTORY** | | | | | |
| Summary of education (current grade or final level completed) | | | | | |
|  | | | | | |
|  | Modified Program |  | Educational Assistant |  | Individual Educational Plan |

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| **HOME OR SUPPORTIVE LIVING ENVIRONMENT** |
| **Living**: What is the current living situation? Please the level of support, number of persons, recreational and community activities available to the person? |
|  |
| **Daily Activities:** Describe a typical day including level of structure needed, activity level and interests/hobbies. |
|  |
| **Spiritual**: Are there any cultural, spiritual or religious needs specific to the person? |
| Person is a member of the Black, Indigenous or People of Colour Community Yes  No  Unknown |
| Person is a member of the LGBTQ2S+ Community Yes  No  Unknown |
|  |

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| **STRENGTHS** |
| List of overall strengths of the person: |

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| **ADDITIONAL COMMENTS** |
| Please provide any additional information that you believe is significant to the person’s care/support (i.e. personality traits, communication style, special needs, mobility or behaviours) that may be helpful to know in assessing and caring for the person. |
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| **EXPECTATIONS FOR DDS** |
| What are you hoping to achieve from this referral to DDS (within the mandate of DDS)? |
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Signature of Person Signature of Family/Care Provider (if applicable)

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Print Name of Person Print Name of Family/Care Provider

Date Date

cc: Main File