Providence Care

Mental Health Services site

PERSONAL HEALTH INFORMATION

Telephone: 613-530-2400
Fax: 613-530-2212

DUAL DIAGNOSIS CONSULTATION OUTREACH TEAM

REFERRAL FORM

CLIENT INFORMATION—Surname | Given Name | Age | Date of Birth (Y/M/D)

Address *Street* | *City, Province* | *Postal Code* | *County*

Telephone | **Health Card Number** | **Ver** | Religion | Birthplace | Ethnic Origin | Marital Status

REFERRING SOURCE—Person initiating referral* | Agency

Address *Street* | *City, Province* | *Postal Code* | *Telephone*

Relation to Client

REQUIRED FOR REFERRAL - A DIAGNOSIS OF

Intellectual Disability (Developmental Disabilty) ☐ and/or
Autism Spectrum Disorder ☐
Documentation supporting the diagnosis of an Intellectual Disability or Autism Spectrum Disorder /PDD attached to the referral is required for the referral to proceed

REFERRAL QUESTIONS

Reason for referral/presenting problem and duration

What is being sought from the Dual Diagnosis Consultation Outreach team?

MEDICAL CONDITIONS/DISABILITIES

For each of the following conditions, indicate ***Identified*** if the client has a formal diagnosis of the condition or if the condition is obviously present (i.e. Down syndrome; wears glasses, therefore is vision impaired). If the condition is suspected but has no formal diagnosis, indicate ***Suspected***.

CONDITION	*Identified*	*Suspected*	CONDITION	*Identified*	*Suspected*	CONDITION	*Identified*	*Suspected*
Behaviour disorder	☐	☐	Vision impairment	☐	☐	Seizure disorder/epilepsy	☐	☐
Communication disorder	☐	☐	Hearing impairment	☐	☐	Cerebral palsy	☐	☐
Mental illness/psychiatric disorder				☐	☐	Down syndrome	☐	☐
Wheelchair dependent				☐	☐	Fragile X syndrome	☐	☐
Mobility impairment but not wheelchair dependent				☐	☐	Rett's syndrome	☐	☐
Technologically dependent/medically fragile (*has intensive medical needs, e.g. feeding tube, tracheostomy)*				☐	☐	Fetal alcohol syndrome	☐	☐
						Dementia	☐	☐

Other conditions which have a significant impact on daily living (i e. insulin dependent diabetes, oxygen (specify))

Primary Care Physician | **Psychiatrist**

List of current medications and their use (please attach additional sheets as needed)

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PERSONAL HEALTH INFORMATION

New referral
Internal referral
Re-opened
Re-opened FAST TRACK

DUAL DIAGNOSIS CONSULTATION OUTREACH TEAM
REFERRAL FORM

Previous psychiatric admissions/involvement ***(i.e. Royal Ottawa Health Care Group; Providence Care- MHS)***

Criminal charges

SUBSTITUTE DECISION MAKER ☐ Yes ☐ No ☐ Unknown

IF YES, NAME**:** _____ Telephone: _____

Power of Attorney for: ☐ Property ☐ Personal Care

***** Referring source has permission to provide information from ☐ Client ☐ Substitute Decision Maker ☐ Does not have permission

NEXT OF KIN—Name	Relationship to Client		
Address *Street*	*City, Province*	*Postal Code*	*Telephone*

Person requiring assistance is aware that this referral is being made: ☐ Yes ☐ No

Who else is aware of this referral/problem?

BACKGROUND INFORMATION

Language and/or communication style commonly used by individual requiring service ☐ English ☐ French ☐ Other *(specify)* _____

☐ Augmentative communication *(specify)* ☐ Sign language or gestures ☐ Non-verbal

Current living arrangements

Education

Other Supports/Agencies Involved (including Primary Worker/Contact for each agency)

Source of Income

☐ Ontario Disability Support Program (ODSP) ☐ Private pension ☐ Employment ☐ Canada Pension Plan (CPP) ☐ Ontario Works

Day Program Status ☐ Day Program ☐ School ☐ Vocational placement ☐ Home ☐ Other

Form completed | | | | | | | | |

Completed by *(Signature)* _____