

Dual Diagnosis Referral Form

NAME:		DATE OF REFERRAL: (dd/mm/yy)	
ADDRESS:		CONTACT PERSON:	PH#:
CITY:		OHIP #:	
PHONE # (h):	(w):	PHYSICIAN:	
D.O.B: (dd/mm/yy)	<input type="checkbox"/> Male / Female <input type="checkbox"/>	PSYCHIATRIST:	
DEVELOPMENTAL DISABILITY: <input type="checkbox"/> Yes / No <input type="checkbox"/>		MENTAL HEALTH DIAGNOSIS: <input type="checkbox"/> Yes / No <input type="checkbox"/>	
<p style="text-align: center;"><u>Neurological Symptoms</u></p> <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Attention Deficit / Hyperactivity <input type="checkbox"/> Confusion / Memory <input type="checkbox"/> Syndrome: _____ <input type="checkbox"/> Other (specify): _____	<p style="text-align: center;"><u>Mental Health Issues</u></p> <input type="checkbox"/> Suicidal Thoughts / Behaviours <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Psychotic Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Other (specify): _____	<p style="text-align: center;"><u>Medical / Physical Issues</u></p> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Vision Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Physical Disability <input type="checkbox"/> Other (specify): _____	
<p style="text-align: center;"><u>Addictions</u></p> <input type="checkbox"/> Alcohol / Drug Abuse <input type="checkbox"/> Alcohol / Drug Dependence <input type="checkbox"/> Substance Related Disorder <input type="checkbox"/> Substance Use: _____ <input type="checkbox"/> Other (specify): _____	<p style="text-align: center;"><u>Psychosocial / Socioeconomic</u></p> <input type="checkbox"/> Lack of Social Support / Isolation <input type="checkbox"/> Homelessness <input type="checkbox"/> Unemployment <input type="checkbox"/> Family / Relationship Issues <input type="checkbox"/> Other (specify): _____	<p style="text-align: center;"><u>Criminal Justice Involvement</u></p> <input type="checkbox"/> Charges Pending <input type="checkbox"/> Pre-Diversion <input type="checkbox"/> Diversion <input type="checkbox"/> Post-Diversion <input type="checkbox"/> Other (specify): _____	
REASON FOR REFERRAL:		Pending Charges (if applicable)	
CRIMINAL INVOLVEMENT: (Dates & Types of Past Convictions)		PROBATION AND PAROLE: <input type="checkbox"/> Yes / No <input type="checkbox"/>	
Lawyer: _____ Phone #: _____		Name of Probation/Parole Officer: _____	
Phone #: _____		Phone #: _____	
<p style="text-align: center;"><u>Intervention Requested</u></p> <input type="checkbox"/> Diagnostic Clarification <input type="checkbox"/> Assessment: _____ <input type="checkbox"/> Medication Consultation / Review <input type="checkbox"/> Diversion / Release Planning <input type="checkbox"/> System Coordination <input type="checkbox"/> Other (specify): _____	<p style="text-align: center;">CURRENT MEDICATIONS:</p>	<p style="text-align: center;">Dosage</p>	<p style="text-align: center;">Date Started</p>

The Degree to which the Individuals Daily Functioning is Impaired by Mental Health Issues?	
<input type="radio"/> Mild Impairment (e.g., falling behind; temporary and/or expected social difficulties; transient and/or expected psychological reactions) <input type="radio"/> Moderate Impairment (e.g., some ongoing difficulties and/or conflicts; few friends; occasional psychological symptoms; or flat affect) <input type="radio"/> Severe Impairment (e.g., unable to work; failing school; no friends; neglect family; severe/persistent psychological or suicidal ideations)	
✓ Check Most Applicable Statement: <input type="radio"/> No Suicidal Thoughts <input type="radio"/> Only Fleeting Suicidal Thoughts <input type="radio"/> Suicidal Thoughts with No Plan <input type="radio"/> Current / Imminent Intent to Suicide <input type="radio"/> Recent Suicide Attempt	Within the last 12 Months - Has the Individual Accessed? <ul style="list-style-type: none"> Crisis Response Emergency Department Mental Health Hospitalization <input type="radio"/> Yes (# of times) _____ <input type="radio"/> No
Chronic History of Mental Health Problems?	Presence of Psychotic Symptoms?
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Significant Trauma within the last 6 Months?	Concern of Pregnancy?
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Is the Individual Currently Homeless or at Risk of Homelessness?	
<input type="radio"/> Yes <input type="radio"/> No	
AGENCY AND PROGRAM INVOLVEMENT:	
Agency:	Program/Worker:
Agency:	Program/Worker:
Agency:	Program/Worker:
ADDITIONAL INFORMATION:	

Referring Agent / Physician / Agency _____
 (Please print clearly)



Please return **Referral** form to:
Dual Diagnosis Facilitator
 Mental Health Outpatient Programs
 St. Joseph's Health Centre
 710 Victoria Avenue East
 Thunder Bay, ON, P7C 5P7
Phone: (807) 624-3433
Cell: (807) 621-9308
Fax: (807) 624-3523

Phone #

Signature

Ref #:	JZ-APR07-002
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