Parkwood Institute
Finch Family Mental Health Care Building
PO BOX 5777, STN B
London, ON N6A 4V2
Phone: 519-455-5110 x47697
Fax: 519-452-4396

Dual Diagnosis Outreach Program Referral Questionnaire – Family to Complete

Name:		**D.O.B.:**
Home Address:		**Postal Code:**
Telephone:	**Health Card #:**	
Is client currently in hospital? If so, please provide date and reason, and name of hospital) **Yes ☐ No ☐**		
Next of Kin:		**Relationship:**
Address:		
Email:		**Telephone:**
Person providing consent for treatment:		**Name:**
Address:		
Telephone:		
Is this identified substitute decision maker aware of this referral: Yes ☐ No ☐		
Name of Referring Physician:		
Address:		**Postal Code:**
Telephone:	**Fax:**	**E-mail:**
Community Case Manager/Contact person:		**Telephone:**
Fax:		**E-mail:**
Family Physician:		**Telephone:**
Address:		**Fax:**
Community Psychiatrist:		
Telephone:		**Fax:**
Pharmacy:		
Telephone:		**Fax:**

Please note that only fully completed referral forms, including all required documentation, will be reviewed. Incomplete referrals will not be processed. This is a consultative service only. Upon completion of the assessment, clinical recommendations will be provided to the referring physician, who remains responsible for ongoing management and implementation of the treatment plan.

DDP Referral Questionnaire….
What mental health symptoms is your client/family member presenting to prompt this referral to DDP? **Define the onset of symptoms and how they presented:**
Family History of Psychiatric Difficulties:
Has this person had psychological testing/ been given a diagnosis? If so, when? (must include a copy of report)
Current Medications:

Family Medical History:

Provide any Family history, level of current involvement:

Describe your client/family member's style of interactions with others including peers, staff, roommates, family, community:

Please identify any significant changes/losses/differences in client's life/lifestyle in past 6 months - one year.

Has the client had any significant experiences in the home/community/family setting that may be affecting their current functioning?

Has your client/family member experienced a history of trauma (physical, sexual, or extreme neglect) that you feel is impacting them at this time?

Define a typical day including level of structure needed, activity level, interests/hobbies:

Educational History:

DDP Referral Questionnaire….

Does the client have any cultural or spiritual needs specific to them?
If so, please explain.

Please describe this person's current difficulties including onset and frequency of problems. Identify recent changes in sleep, eating, interests, coping, mood, behaviors, interactions, etc.

How does this differ from this individual's typical presentation?

_____

Please identify three overall strengths of the referred individual:

1.

2.

3.

List agencies/community supports (past and/or present) to individual and/or family: (Length and level of involvement of service)

1.

2.

3.

Community Placement: (In order to understand the environment your client resides in, please explain the current living situation in detail, including no.of residents, staffing levels, structure, community activities, layout of the home)

Plan for individual's residential needs in the community, currently and in the future:

Is the Individual deemed financially competent? Yes _____ No ____ **If not, who provides consent? _____** **Do they require assistance with their finances? Yes ____ No ____**
DDP Referral Questionnaire….
What are your expectations regarding your client's treatment?
Is there any other information significant to this individual's care/support (i.e. personality traits, communication style, special needs, mobility, behaviours that are helpful to know in assessing and caring for them?

***Is the patient involved with Developmental Services Ontario? Yes ____ No_____** *** Does patient and or SDM consent to referral? Yes _____ No_____**

Thank you for taking the time to complete this questionnaire.

The Dual Diagnosis Outreach Team.

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Name of Person Completing the Form/Relationship to Patient/Signature