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 – Physician 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:**
Individual Psychiatric History: (previous psychiatric hospitalizations, institutionalizations, past involvement with DBM/DDP, ongoing community psychiatry)
Has this person had psychological testing/ been given a diagnosis? If so, when? (must include a copy of report)

Current Medications:	**Historical Psychiatric Medication and Outcomes:**

DDP Referral Questionnaire….

What are your expectations regarding your client's treatment?

***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.

Physician Signature

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.