



Specialized Clinical DS Network

DUAL DIAGNOSIS ALTERNATE LEVEL OF CARE COLLABORATIVE CLINIC

Case Consultation Referral Form

Please complete all sections and return to admin@scdsn.org

Personal Information			
Name	FirstLastInitial (s)		
Health Card Number	Health Card NumberVersion Code		
Date of Birth	dd-mmm-yyyy	Gender	Male Select oneIf Other, please specify
Current Living Situation	Family Home Select oneRegion If Other, please specify		
Address	Street ON CityProvPostal Code		
Emergency Contact/Sub. Decision Maker	Name: Relationship to client: Telephone: Email:		
Proof of DSO Eligibility	Supports Intensity Scale Information Date of most recent SIS assessment: SIS Scores: Medical Behavioural Overall		
Available Funding Sources	Check all that apply: ☐ Passport Annual Amount: ☐ Private Benefits ☐ Other Please describe:		

Referral Information	
Date of Referral	_____ (dd-mmm-yyyy)
Referral Source	Name: _____ Relationship to client: _____ Telephone: _____ Email: _____
	Is referral Source the Clients' Primary Contact? ☐ Yes ☐ No If not provide primary contact information: Name: _____ Relationship to client: _____ Telephone: _____ Email: _____
Reason for Referral	
Describe the Reason for the Consultation Request ☐ Treatment Recommendations ☐ Behaviour Support Strategies ☐ Community Resource Recommendations ☐ Staff Capacity Building ☐ Medication Considerations (to follow up with family physician etc.) ☐ Other _____	Briefly Describe the Reason for the Consultation:
Desired Outcomes	
Based on the reasons indicated above, what would a successful consultation look like? 	

Clinical Information	
Diagnosis	Please list all applicable developmental, medical and psychiatric diagnoses:
Primary Care Provider/Family Doctor	Name: _____ Phone Number: _____ Aware of Referral? ☐ Yes ☐ No _____ General Practitioner/Family Doctor Signature Date

Clinical Features

Please check all that apply:

- | | | |
|--|---|---|
| ☐ Pronounced low mood
☐ Irritability / Anger
☐ Pronounced Anxiety/Panic
☐ Repetitive/Obsessive
☐ Compulsive Behaviours
☐ Elevated mood/ Increased energy
☐ Insomnia/decreased sleep
☐ Hypersomnia
☐ Pronounced self-neglect
☐ Refusal to participate in daily activities
☐ Inability to cope with life stress | ☐ Mood dysregulation
☐ Aggressive Behaviour(s)
☐ Self-Injurious Behaviour
☐ Self-Harm:
occurred/occurring
☐ Risk of harm to self:
plan / intent
☐ Risk of harm to others:
plan / intent
☐ Sexual assault
☐ Physical Assault
☐ Traumatic event | ☐ Change in personality
☐ Psychotic Symptoms
☐ Pronounced Confusion
☐ Attention concentration issues
☐ Significant weight gain/loss
☐ Communication challenges
☐ Chronic pain
☐ Substance Use
☐ Other: _____ |
|--|---|---|

Current Medications

(including All prescriptions, OTC, herbals, PRNs)

Name	Dosage	Frequency	Indication & Start Date

Previous Medication trials and any adverse reactions

Precipitating Factors/Risk Factors

Strengths and Protective Factors

Serious Occurrence Reports (SOR)	
How many SORs has the person had in the last six months?	
Provide a list of the types of SORs made	
How many Emergency Room visits in the last six months?	
Please provide any additional information about any readmissions to hospital in the last six months	

Biopsychosocial and Additional Information	
Post Alternate Level of Care History	Since transitioning from ALC what has happened that prompted this referral? What has worked/not worked? <i>Please be brief and <u>specific to the reason for the referral</u></i>
Current Supports	
Please list all supports the person has in place specifically DSO/Agency involvement, Mental Health care/practitioners, Primary Care, Specialists etc.	
Current Concerns/Challenges	
Please briefly list current challenges concerns (as relates to this referral)	

Additional Documentation

Please check off documentation provided with this referral.

- ☐ Proof of Intellectual and/or developmental disability
- ☐ Formal Psychiatric Diagnosis(es) including reports
- ☐ Psychological Assessments
- ☐ Functional Behaviour Assessment
- ☐ Behaviour Support Plan (BSP)
- ☐ Occupational Therapy (OT) Assessment
- ☐ Speech and Language Pathology (SLP) Assessment
- ☐ Blood work/other investigations
- ☐ Other medical assessments/reports (Please list)

Capacity Building Modules

These clinics are part of a multi-streamed approach to build and support sustainable capacity within the Developmental Services sector. The first stream was creating four video modules on understanding Dual Diagnosis, Crisis Prevention and De-escalation, Clinical Transition Planning and Fostering Resiliency and Trust. These modules are available on the REAL Xchange.

- ☐ Have you completed the SCDSN Capacity Building in the DS Sector modules on REAL Xchange at the time of this referral?