St. Joseph's Healthcare Hamilton

REFERRAL FORM
DEVELOPMENTAL DUAL DIAGNOSIS OUTPATIENT PROGRAM

100 West 5th St. Hamilton, ON L8N 3K7

An integrated, shared-service model providing specialized care to adults with an intellectual developmental disability and complex mental health needs living in Hamilton, Niagara, Haldimand, Norfolk, Brant, and City of Burlington

Telephone: (905) 522-1155 ext. 36610 **Fax: (905) 381-5619**

Patient Name: _____	Date of Referral: _____
Address: _____	Referring Physician/Facility/Agency:
City: _____ PC: _____	Contact Person:
Telephone: _____	Tel #/Extension:
Date of Birth: _____ Age: _____	Interpreter Required: □ Yes Language: _____
HIN: _____ VC: _____	**Client/SDM aware of and consents to this referral?** □ Yes □ No Reason:_____
Living Arrangement: □ Alone □ Family □ Group Home □ Lodging Home □ Other:	**Previous client of the Dual Diagnosis Program?** □ Yes □ No
CAREGIVER/NEXT Of KIN/SUBSTITUTE DECISION MAKER	**FAMILY PHYSICIAN**
Name:	Name:
Substitute Decision Maker: □ Yes □ No	Address:
Relationship:	Telephone (Back Line #):
Telephone:	Fax:
Contact Person for Appointments: □ Client □ Caregiver/NOK/SDM	***Physician contact information needs to be complete**

COMMUNITY AGENCIES INVOLED

Is this patient supported by Developmental Services Ontario (DSO)? □ Yes □ No □ Unknown
Is this patient supported by Central West Specialized Developmental Services (CWDS)? □ Yes □ No □ Unknown
Has a referral been made to Twin Lakes Clinical Services for Psychiatry? □ Yes □ No □ Unknown
Please check all that apply:
□ Hamilton Brant Behavior Services □ Bethesda □ Bartimaeus □ Community Living □ CHOICES
□ Good Shepherd □ Salvation Army/Lawson Ministries □ Christian Horizons □ CCAC
□ Catholic Family Services □ Canadian Mental Health Association □ Other:

HEALTH INFORMATION

Reason for Referral: **(Note: Diagnosis is not a reason for referral)**

_____

_____

_____

If this referral is **URGENT**, please indicate why:

Please ensure referral form is <u>complete</u> and all information requested is attached. Incomplete referrals will delay processing and may be returned for completion. Please note this is <u>NOT</u> a crisis service.

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Medication List: (can attach current medication record)

Allergies:

Relevant Medical/Psychiatric History:

_____

_____

_____

***Please include any documentation to support Intellectual Developmental Disability (e.g., psychological testing, IQ testing), recent consultation notes, and discharge summaries**

Associated Risk Factors:

□ Suicidal Ideation/Attempts □ Aggressive Behavior □ Property Damage □ Substance Use/Misuse
□ Elopement □ Self-Injurious Behavior □ Caregiver Burden/Stress □ Legal Issues
□ Other:

Please forward most recent bloodwork and any investigations (i.e., CT Scan, EEG, MRI) which have been completed**.**

If bloodwork/urinalysis has not been completed within the <u>past 6 months</u>, we would recommend the following:

□ CBC with Diff (WBC) □ Electrolytes □ Liver Function (AST, ALT, BILI, ALP, GGT) □ Creatinine
□ TSH □ Albumin □ Vitamin B12 □ Glucose □ Calcium/Magnesium/Phosphate

_____

Family Physician Signature OHIP Billing # Date: (yyyy/mm/dd)

_____

Referring Physician Signature OHIP Billing # Date (yyyy/mm/dd)

Please fax completed referral package to (905) 381-5619

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