The Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

COMMUNITY MENTAL HEALTH PROGRAM
2121 Carling Avenue, Suite 201, Ottawa, ON K2A 1H2
Phone: 613.722.6521, ext 7141 Fax: 613.798.2976

Referral Form

Regional Dual Diagnosis Consultation Team (RDDCT) and
Flexible Assertive Community Treatment Team for Persons Dually Diagnosed (FACTT-DD)

❑ **Family physician is aware of and agrees with this referral**

CLIENT NAME: _____ DOB: _____

The Dual Diagnosis Services of the Community Mental Health Program is comprised of the Regional Dual Diagnosis Consultation Team (RDDCT) and the Flexible Assertive Community Treatment Team for Persons Dually Diagnosed (FACTT-DD). These teams serve residents of the Champlain LHIN aged 18 and older with an intellectual disability and symptoms of mental illness. These teams do not address ADHD or Neurocognitive Disorders unless the individual also meets the first two criteria. Physician or Nurse Practioner referral is required. If further information is required, please call 613.722.6521, ext 7141.

Client Information

Gender: ❑ Male ❑ Female
Language: ❑ English ❑ French
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Common Law
Other: _____
Aboriginal Origin: ❑ Yes ❑ No ❑ Not specified
Translator required? ❑ Yes ❑ No

Client's Address: _____ Preferred Phone Number: _____

_____

Postal Code: _____ Alternate Phone Number: _____

OHIP Number: _____ Version Code: _____

Primary Caregiver Contact Information

Name: _____ Relationship to Client: _____
Address: _____
Postal Code: _____ Preferred Phone Number: _____

Next of Kin Contact Information (if different from Primary Care)

Name: _____ Relationship to Client: _____
Address: _____
Postal Code: _____ Preferred Phone Number: _____

Is there a Substitute Decision Maker?

❑ Yes ❑ No ❑ Unknown
Name: _____ Relationship to Client: _____
Address: _____
Postal Code: _____ Preferred Phone Number: _____

Family Physician

Phone Number: _____
Address: _____ Fax Number: _____
Postal Code : _____ Email : _____

Referral Information

Phone Number: _____
Name of Referring Physician/Source (If not Family Physician): _____ Fax Number: _____
Postal Code : _____ Email : _____

The Royal's Dual Diagnosis Services Referral Form

CLIENT NAME: _____ DOB: _____

Reason for Referral

- ❑ Diagnostic Clarification
- ❑ Treatment Recommendations
- ❑ Medication Review
- ❑ Currently Hospitalized
- ❑ Recent Changes in Mental Health Status
- ❑ Long Standing Mental Health Challenges
- ❑ System Navigation
- ❑ Frequent use of Emergency Department
- ❑ Length of Hospitalization:
  - ❑ 90 consecutive days
  - ❑ 150 days over the course of 3 years
  - ❑ other
- ❑ Frequent use of Police Services
- ❑ Imminent Risk to Self or Others
- ❑ Lack of Social and Community Connections

Please describe your clinical questions as specifically as possible: _____

_____

Diagnosis of Intellectual Disability

Cause and Level of Intellectual Disability: _____

Diagnosis Provided by: _____

❑ Psychological Assessment Attached ❑ No Documentation on File

Psychiatric Diagnosis

❑ Supporting Documentation Attached (e.g. Psychiatric Consultation Report) ❑ No Documentation on File

Medical Diagnosis

Date of last complete physical/medical examination: (dd___/mm___/year___)

Please attach the following and fax with the referral:

❑ Current Physical Exam Results ❑ Recent Surgeries (Medical or Dental) ❑ Most Recent Blood Work Results

Current Medications **(please fax a list with the referral):** _____

Dispensing Pharmacy: _____ Phone Number: _____

Please list any barriers to obtaining this information: _____

Is the client presently seeing or have they recently seen any specialists?
If yes, please attach the following: name, specialty, and include diagnostic and consultation results. _____

_____

Is the client currently being supported by any community agencies? (please list all agencies) _____

_____

Is there past agency involvement that has been discontinued? _____

_____

Is there other information we should be aware of about current physical or mental health issues? _____

_____

OCTOBER 2015

Date: _____ Completed by (print name): _____

Signature and Designation: _____