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Dual Diagnosis Services –
Flexible Assertive Community Treatment Team for Persons Dually Diagnosed (FACTT-DD)
Community Mental Health Program
Brockville Mental Health Centre
1804 Oxford Avenue, Brockville, ON K6V 5W7
Phone: 613-345-1461, ext 1500 Fax: 613-345-0010

Referral Form

☐ **Family physician is aware and agrees with this referral**

CLIENT NAME: _____ **DOB:** _____

The FACTTDD Team located in Brockville, Ontario serves residents of the Lanark, Leeds & Grenville region aged 18 and older with an intellectual disability and symptoms of mental illness.

Please complete this referral form and fax it to 613-345-0010

Client Information

Gender: ❑ Male ❑ Female

Language: ❑ English ❑ French

Other:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Common Law

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?

_____

Date: _____ Completed by (print name): _____

Signature and Designation: _____