Dual Diagnosis Outpatient Clinic
850 King Street West
Kitchener, ON N2G 1E8
Phone:519-749-4300 ext. 3928
Fax: 519-894-8308

GRAND RIVER HOSPITAL
Advancing Exceptional Care

Dual Diagnosis Outpatient Psychiatry Referral Questionnaire

Date of Referral *(MM/DD/YYYY)*:

Patient Legal Name:	Date of Birth: *(MM/DD/YYYY)*:

Patient Home Address:
Patient preferred name and gender pronouns:
Telephone:
Health Card #: Version code: Expiry:
What is their current living arrangement?

Aside from the service coordinator, who will attend appointments alongside the patient?

Patient capable of consenting to their own treatment? Yes / No *(circle)*
If no, who determined this and when was this that they were determined to be incapable of consenting to their own medical treatment:

If patient is not capable of consenting to their own treatment, who is or would be their SDM (Substitute Decision Maker)?:
Relationship:
Phone number:

Service coordinator (Required*):

Agency:
Address:
Phone:
Fax:

Family Physician (Required *):

Address:
Fax:
Billing number:

Pharmacy:
Address:
Phone:
Fax:

Please list any other pertinent support persons (e*xamples include DSO worker, Occupational therapist, Behaviour therapist, Psychologist, Social Worker, Respite worker, etc)*:

Dual Diagnosis Outpatient Psychiatry Referral Questionnaire

What are you hoping the Psychiatrist will help with? (*ie how can we help?*)

Please describe any relevant behaviours that challenge (*aggression, self-injurious behaviour, etc*):
When did this begin? (*approx*)
When did this worsen?
How often does this occur?
How is this being addressed currently?

Please Describe Pertinent Psychiatric History:
Please include discharge summary from most recent hospitalization if applicable
Please list what you understand their diagnoses to be as well as whether you agree/disagree with these diagnoses

Age when Intellectual Disability or ASD was first diagnosed:

Whom diagnosed them and please provide a copy of this report

Current Psychiatric Medication: *Please include approximate start date (MM/YY), reason for use, current dose, last dose change, any helpful effects and any side effects*	Current PRN medication? *Please include approximate start date, dose, how often this has been given over the last 6 months (daily, weekly, monthly, etc), any helpful effects, side effects.*

Dual Diagnosis Outpatient Psychiatry Referral Questionnaire

Medical History:

Please list any medical issues below:
Note long this has been an issue, any pertinent treatment (medications, surgeries, etc)

Please note if these medical conditions are present:

Heart disease or surgeries: *Yes / No - if yes, please describe in space below*
Epilepsy or seizures: *Yes / No - if yes, please describe in space below*
Obstructive sleep apnea: *Yes / No - if yes, please describe in space below*

Visual Impairment: Yes ___ No ___

Hearing Impairment: Yes___ No ___

Allergies: *(Please list any allergies to any medication and what happens)*

Dual Diagnosis Outpatient Psychiatry Referral Questionnaire

Developmental Disorders:

Is there a known syndrome or genetics finding present? *Yes / No (please circle)*
Examples include Down syndrome, Fragile X, 22Q11 deletion syndrome, etc

Has a chromosomal microarray/genetic testing been completed? *Yes / No (please circle)*
If yes, please include a copy of this report

Obstetrical History ie Pregnancy:

Was this pregnancy planned or unexpected? *(please circle answer)*
How old was mom and dad when became pregnant? *(please list)*

Are parents related in any way other than through conceiving their child(ren) *- yes / no*
Examples may include being first cousins. If yes, please describe biological relationship and any shared relatives in the space below

How much alcohol would have been typical for mom to have consumed prior to knowledge of this pregnancy?
Please list approximate frequency and estimated amount - for example twice weekly 2-3 drinks

Was there any tobacco, cannabis or other substance use during the pregnancy? *yes / no*
Please list amount, frequency of use, and duration of pregnancy where this was used

Please circle and describe if any medical complications occurred during the pregnancy.
Examples may include maternal infections, hypertension, diabetes, intractable nausea, domestic violence, etc.

Please describe the setting and pertinent information re: labour and delivery:
For example - Born at 41 weeks 2 days by standard vaginal delivery, with midwife support.

Was there any concern about fetal heart rate, nuchal cord around the neck, meconium aspiration, etc - Please describe below if yes:

Were there any health issues in the first few months of life? *Yes / No (please list below if yes)*
Examples include newborn infections, neonatal jaundice, concerns about growth or feeding, etc

Dual Diagnosis Outpatient Psychiatry Referral Questionnaire

Developmental history:

When did parents first have concerns about their development and what were these concerns? Please describe in detail below

Please list the approximate age in months for each of the following:
Walking:
First words:
Speaking with 20 words:
Speaking with 2 word combinations:
Please describe any concerns with speech and language use prior to school entry.

Has your client/family member experienced a history of trauma (physical, sexual, or extreme neglect) - *yes / no (circle type of trauma(s))*
If yes, please describe if appropriate

Toileting and hygiene:
Please describe how much support is needed to complete these tasks reliably.

Daily Living Skills:
Please describe what each day of the week involves for this person. This may include structured and/or unstructured activities.

Educational History:
Please describe when concerns arose at school and what these concerns were.

Please describe if there were any specific needed accommodations/modifications in education delivery, such as being placed in a developmental classroom.

Dual Diagnosis Outpatient Psychiatry Referral Questionnaire

Please describe if there are specific mental health related symptoms of concern below:
Sleep:
Please note usual bedtime and waketime:
Mood:
Hyperactivity:
Anxiety/Fear/Nervousness:

Substance Use:
Please describe current pattern (amount, frequency, etc) of substance use and any pertinent concerns in this area:

Safety:
Please describe if current difficulties with self harm and/or suicidality:

Please describe in detail if previous suicide attempts have occurred:

Family history:
Please describe if any relatives with a history of bipolar disorder, schizophrenia.

Please describe if any family history of ADHD, Autism/ASD, Learning difficulties, Intellectual Disabilities.

Is there any family history of heart attack, arrhythmia, sudden death or drowning in those under age 50yrs – *yes/ no (please circle)*
If yes, please describe below

Please list names for both mom and dad. What is their furthest education completed, as well as their vocation?

Thank you for taking the time to complete this questionnaire.

Please attach any additional information that you feel would be important to our assessment

DD Use Only

Checklist:

Service Coordinator and agency name- yes / no

Psychological assessment attached – yes / no
Meets criteria for clinic (ID or ASD) - yes / no
Genetics results attached – yes / no
Most recent discharge summary attached – yes / no
Substance use, Safety concern or Psychosis - yes / no (if yes, bring to monthly meeting to assess fit for service)

Date received completed: