Kenora Association for Community Living
A Meaningful and Satisfying Life

Community Mental Health Support Services
Dual Diagnosis

Dual diagnosis services provide specialized services under the bio-psycho-social-spiritual model to adults living in the Kenora/Rainy River District who meet the criteria for dual diagnosis. Dual Diagnosis refers to the co-existence of an intellectual disability and a mental health concern. This includes individuals who have had a history of unclear diagnoses and complex issues who have had difficulty accessing resources in their communities. Referrals can be made by individuals, family, physicians, psychiatrists or other service providers. A brief list of available services are described below:

Psychiatric Services:

Dual Diagnosis Psychiatry services are provided through a clinical consultative model including medication review, specific assessment, assistance, recommendations and advocacy.

Mino Ayaawin Services:

Mino Ayaawin services provide identity based learning rooted in the traditional teachings of the Anishinaabe. The Seven Grandfather teachings are the foundational approach of the Mino-Ayaawin consultant to connect individuals with themselves, the land, ceremony, and community, all of which are pertinent to an Indigenous person's identity.

Occupational Therapy Services:

Occupational Therapy services are provided on a consult basis for individuals seeking support with improving function in areas such as activities of daily living, sensory processing, pain/fatigue, roles and interests, gross/fine motor skills, and cognition/executive functioning. Services are provided through assessment and recommendations.

Behavioral Therapy Services:

Behavioural Therapy services are provided on a consult basis for support with identifying and altering unhealthy, maladaptive, or destructive behaviours through assessment and recommendations.

Community Mental Health Support Services
Dual Diagnosis Referral Form

Consent to Disclose: ◯ written ◯ verbal ◯ Release of information attached

Name: _____ Referral Date: _____

Indigenous/Non-Indigenous: _____ Date of Birth: _____

Spirit Name: _____ First Nation Community: _____

Clan: _____ Spirit Colors: _____

Gender: _____ Marital Status: _____ Preferred Language: _____

Health Card #: _____ VC: ___ Expiry date: _____

Address: _____ Postal Code: _____

Phone Number: _____ Permission to Contact? ◯ Yes ◯ No

Referring Person: _____ Address: _____

Phone Number: _____ Permission to Contact? ◯ Yes ◯ No

Physician: _____ Phone Number: _____

Physician OHIP Provider #: _____

Service request explanation:

Please be specific in your requests

_____

_____

_____

_____

_____

_____

_____

_____

Central Office ● Children's Services ● Options for Adults ● Community Mental Health Support Services
12 Main Street South, Kenora, Ontario P9N 1S7
P (807) 467-5257 ● F (807) 467-5264
kacl.ca

Presenting Issues:

- ◯ Activities of Daily Living
- ◯ Occupational/educational/vocational
- ◯ Relationship problems
- ◯ Financial management
- ◯ Physical abuse
- ◯ Sexual Abuse
- ◯ Other: _____
- ◯ Substance Abuse
- ◯ Legal
- ◯ Seriously mentally ill
- ◯ Suicidal
- ◯ Housing
- ◯ Trauma
- ◯ Chronic pain/Fatigue

Legal status: ◯ No legal problems ◯ Civil ◯ Criminal

Legal status continued:

- ◯ On parole
- ◯ Conditional discharge
- ◯ Court diversion
- ◯ On probation
- ◯ Awaiting sentence
- ◯ Conditional sentence
- ◯ Unfit to stand trial
- ◯ Charges withdrawn
- ◯ Restraining order
- ◯ Awaiting trial
- ◯ Not criminally responsible
- ◯ Peace bond

Living arrangement:

- ◯ Unknown/declined
- ◯ Private house/apt/owned/market rent
- ◯ Hostel/shelter
- ◯ Private non-profit housing
- ◯ Municipal non-profit housing
- ◯ Retirement home/seniors residence
- ◯ Private House/apt/subsidized
- ◯ Approved homes/homes for special care
- ◯ LTC facility/nursing home
- ◯ Correctional/probation facility
- ◯ Other specialty care hospital
- ◯ Psychiatric hospital
- ◯ General hospital
- ◯ Supportive housing congregate living
- ◯ Supportive housing assisted living
- ◯ Domiciliary hospital
- ◯ Homeless
- ◯ Rooming/boarding house
- ◯ No fixed address
- ◯ Other: _____

Residential Support:

- ◯ Unknown/Declined
- ◯ Independent
- ◯ Assisted/supported
- ◯ Supervised Facility
- ◯ Supervised non-facility

Please indicate areas of concern:

- ◯ Prescription abuse
- ◯ Drug/alcohol illicit abuse
- ◯ Current/history of arson
- ◯ History of child abuse
- ◯ Current/history of weapon use
- ◯ Other: _____
- ◯ Current/history of violence toward others
- ◯ Medical complications
- ◯ Non-compliance with medications
- ◯ Current/history of police involvement
- ◯ Special Diet

Please indicate the following for the past year prior to referral:

Number of emergency room visits related to mental health: _____

Number of emergency room visits related to chronic health: _____

Number of admission to schedule 1 psychiatric hospital: _____

Number of days admitted to schedule 1 psychiatric hospital: _____

Number of police contacts: _____

Severity of incidents involving police (high, medium, low): _____

Number of days incarcerated: _____

Number of days in stable housing: _____

Case Manager
/Service Coordinator: _____ Phone Number: _____

Power of attorney: _____ Phone Number: _____

Medical alerts (conditions, diseases, illnesses): _____

_____

Existing mental health diagnosis? Please list: _____

_____

_____

Intellectual disability? Please list syndrome if known: _____

_____

Please circle: mild / moderate / severe / profound IQ if known: _____

The referral source will receive a response regarding service eligibility and acceptance within a timely period. The timely period begins when there is sufficient information provided by the referral source.