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.

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 Consultant

Based on the recommendations from our service providers, the Dual Diagnosis Community Consultant offers individualized 1:1 support to implement strategies within the community.

Should you have any questions when completing the referral document or intake package please do not hesitate to contact
Jennifer Reimer, Manager in the Dual Diagnosis Program, for assistance at jreimer@kacl.ca or 807-464-0201.
Thank you.

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

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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): ________________________

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Existing mental health diagnosis? Please list: ________________________

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____

Intellectual disability? Please list syndrome if known: ________________________

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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.