Canadian Mental Health Association
Ottawa
Mental health for all

Association canadienne pour la santé mentale
Ottawa
La santé mentale pour tous

DUAL DIAGNOSIS SERVICES

Case Management

CMHA Ottawa's Dual Diagnosis Services provides short term client directed case management support to adults who have a mental illness ***and*** an intellectual and/or developmental disability. Referrals for Case Management are for adults who additionally have current court/legal issues.

Person being referred:

Name: _____ Age: _____ Date of birth: _____

Address: _____ Gender: ☐ Female ☐ Male ☐ Other

_____ ☐ English ☐ French

Telephone: _____ ☐ Other (specify) _____

Referral Source (if different):

Name: _____ Relation to referred person: _____

Address: _____

_____

_____

Telephone: _____

Are you currently receiving services or have you received services in the past from:

Service Coordination ☐

Developmental Services Ontario ☐

Mental Health Community Support Services? ☐

FACT (Flexible Assertive Community Treatment Team - Royal Ottawa Mental Health Centre) ☐

Valoris - Solution-s/ ☐

Behaviour Management Program ☐

Other: _____

Diagnoses (developmental, mental, physical)

Developmental Disability:	Mental Health Issue(s):	Physical Disability / Health Issues / Other:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason(s) for referral

_____
_____
_____
_____

Health and safety/risk factors associated in supporting this person

_____
_____
_____
_____

Who are the current members of the support network (i.e. family, informal, professional)?

Name	Role/ Agency	Contact #

Does this person have a Substitute Decision Maker / Power of Attorney for Personal Care? If so, please provide contact information here:

_____

Consent and waiver

I, or the Substitute Decision Maker for _____ (name, date of birth), consent for the Canadian Mental Health Association, Ottawa Branch, to collect, discuss with and disclose my personal health information to the individuals/agencies listed below that I have **checked off** for the purpose of determining my service eligibility and service needs.

	Referring Person/Agency : *Contact Info:*		Psychiatrist / Hospital : *Contact Info:*
	Service Coordination des Services		Lawyer : *Contact Info:*
	Developmental Services Ontario		Probation / Parole Officer : *Contact Info:*
	Substitute Decision Maker : *Contact Info:*		Other: *Contact Info:*
	Mental Health Community Support Services		Other: *Contact Info:*

I consent to participate in the intake/assessment for the Dual Diagnosis Services through the Canadian Mental Health Association (Ottawa). I am aware that I can change or cancel my consent at any time.

Signature of person being referred / Substitute Decision Maker: _____

Signature of referral agent: _____ Date: _____