DUAL DIAGNOSIS JUSTICE CASE MANAGEMENT PROGRAM
REFERRAL FORM

PERSONAL INFORMATION

Name: _____ DOB: d/____ m/____ y/____

Address: _____
Street City Postal Code

Phone #: _____

Substitute Decision Maker Name: _____

Address: _____
Street City Postal Code

Phone #: _____

LIVING SITUATION at time of Referral

☐ Independent	☐ Group Home	☐ Hospital
☐ With Family	☐ Shelter	☐ Homeless
☐ Supported Housing	☐ Correctional Facility	☐ Safe Bed
Other:		

REFERRAL INFORMATION

Referral Source: _____ Phone Number: _____

Address: _____
Street City Postal Code

Contact Person (if other than referral source) _____ Phone #: _____

Services Provided: _____

REFERRAL SOURCE

☐ Community Agency	☐ Court Diversion	☐ Court System
☐ DSO	☐ Family/Friend	☐ Hospital
☐ Jail	☐ Network Partner	☐ Police Referral
☐ Probations & Parole	☐ School	☐ Self
☐ Short Term Crisis Support Bed		
☐ Other:		

REASON FOR REFERRAL

☐ At risk of homelessness	☐ Behavioural Issues	☐ Family Status has changed
☐ Homelessness	☐ Lack of Community Support	
☐ Mental Health	☐ Safety Concerns	☐ Legal Issue
☐ Other		

EXPECTED OUTCOME OF REFERRAL (be specific)

☐ Linked to DSO
☐ Linked to Housing
☐ Linked to Social Services

Developmental Services Ontario was contacted: Yes ☐ No ☐

_____ _____
Signature of Referral Source Date

Please fax completed referral to: 905-685-7093
Attention Dual Diagnosis Justice Case Management Program
or
Mail to: Dual Diagnosis Justice Case Management Program
3250 Schmon Parkway, Unit 10
Thorold, Ontario L2V 4Y6

Please fax completed referral to: 905-318-9343
Attention Dual Diagnosis Justice Case Management Program
or
Mail to: Dual Diagnosis Justice Case Management Program
550 Fennell Avenue East, Unit 16 A
Hamilton, Ontario L8V 4S9

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