Dual Diagnosis Consultation Format

The following format **suggests/recommends** the type of information and ways of organizing material for a case consultation. These points may provide a terms of reference for questions or assistance required from the Dual Diagnosis Committee. These points are intended to cue the presenter. A consultation is intended to build upon the information gathered and received, and the information may be valuable in providing potential cues to planning and treatment. In completing the "Consultation Format", it should be noted that all information categories may not apply to each individual.

A. Identifying Information:

Age: ________ Gender: ❒ Male ❒ Female

Level of Cognitive Functioning:

Mild: ❒ Moderate: ❒ Severe: ❒ Profound: ❒

Primary Disability:____

Secondary Disability:______________________________________

Psychiatric Diagnosis:_____________________________________ Date (year):_____

What levels of support does the individual require (please check):

❑ **Intermittent**: Supports on an "as needed basis". Characterized by episodic nature, person not always needing the support(s), or short-term support needed during life-span transitions. Intermittent supports may be high or low intensity when provided.

❑ **Limited**: An intensity of supports characterized by consistency over time, time-limited but not of an intermittent nature, may require fewer staff members and less cost than more intense levels of support.

❑ **Extensive**: Supports characterized by regular involvement (ie. Daily) in at least some environments (work or home) and not time-limited.

❑ **Intensive**: Supports characterized by their constancy, high intensity; provided across environments; potential life-sustaining nature. Intensive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports.

What is the nature of the individual's communication (please check):

❑ **Active Participation:** This individual could actively and independently participate as he/she has adequate understanding of spoken language for daily activities; his/her speech can be understood by familiar partners; or he/she used a letter based augmentative communication system independently, etc. This person would provide all information directly to the support person.

❑ **Supported Participation**: This individual's speech might be understood by familiar supporters only; he/she may require rephrasing of questions to accommodate language or cognitive comprehension problems. The support for this person would involve direct (not interpretive) translation of messages by a familiar and trained significant other acting as a mediator.

❑ **Third Party Interpretation:** Client profile characteristics for this individual would indicate the need for familiar people to "speak on behalf" of the client. Profiles might include inability to consistently communicate Yes or No; preferences communicated via behaviour or early communicative modes (eg. Pointing, facial expressions, gestures, etc.). The support for this individual should include 2-3 significant others as the range of interpretation typically is a recognized problem with this.

Living Arrangements:

Group Home: ❒ Apartment: Alone ❒ or Roommates ❒ With Family: ❒

Other: ____

Current Supports:

Provided by: ____

B. Presenting Problem:

Reason for Referral: ____

____

____

____

Goal of Consultation:

Resources/Support Hrs: ☐ Ideas/Brainstorming: ☐ Housing: ☐ Day Programs: ☐

Other: ____

____

Chronology of Current Problems and Events leading to it:

Where, When, and How often the Problem occurs:

Detailed Description of the Current Problem (attach additional sheet if necessary):

____

____

____

Locations: ______________________ Seasons:______________________

Time: (Month, Day, or time of Day) ____

Onset: Date: ____________________ (day/month/year)

Impact of the Problem on the individual or others:

Individual: ____

Others: ____

C. History of the Problem

Past Approaches to the Problem & Degree of success: ______________________________

____

____

Services/Supports previously Involved (List):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Opinions of Caregivers or Clinicians on: Why the problems are occurring or solutions to the problems.

____

____

____

____

Legal Issues or Considerations: ______________________________

____

D. Developmental and Social History:

Etiology of Developmental Delay (eg. Genetic, Birth Complications, etc)

____

____

Adaptive Skills:

Changes in: ______________________________

____

Ability to Compensate:______________________________

____

Significant Psycho-social Issues (Life Changes, History of Early Loss or Trauma, etc.):

____

____

____

Family History (eg. Psychiatric Illnesses, Family relationships/strengths/concerns/Involvement):

____

____

____

Cultural/Language Issues:

____

Sexual Issues:____

Strengths/Deficits of Formal Support Systems:

Strengths/Deficits of Informal Support Systems:

E. Medical Conditions:

Physical-medical history/features:

Substance Abuse: Drugs ☐ Alcohol ☐ Other ☐

Dental:

Medications History (Past & Present): (Include: Medication Name/Dosage/Administration Time on separate sheet):

Response to Medications Data:

Administration of PRN's (Name and pattern of use):

Sensory Deficits (ie. Hearing):

Hormonal Fluctuations:

Bowel Function:

Allergies:

Diet:

F. Symptoms and Signs:

Sleep Data/Changes in sleeping patterns:

Appetite Data: ____

____

____

Behavioural Observations/Data: Note if ABC charts (tracks what happens before and after an occurrence) or Behaviour charts are completed:

____

____

____

Is time-out being used and how often? ____

Mood/Mood Charts: ____

____

Changes in Inter-personal functioning: ____

____

Changes in Sexual Functioning: ____

____

G. Precipitating Factors

Environmental Factors/stressors:

Home: ____________________________ Work: ____________________________

School: ____________________________ Social: ____________________________

Friends: ____________________________ Other: ____________________________

Recent Changes or Events significant to the client (Positive or Negative):

____

____

Recent Losses (staff, routine, work, etc.):

____

____

Idiosyncratic Sensitivities (ie. noise, stimulation, etc.):

______________________ ______________________ ______________________

Other Factors that contribute to the behaviours (Positive/Negative):

Positive: ____

Negative: ____

H. List Agencies/Services/Clinicians Involved with Individual:

	Service/Clinician	When	Assessments/Opinions
1.			
2.			
3.			
4.			
5.			