| **Date of Birth:** | | | **Client Name:** | | | | | | | | | | | | | **CID:** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | | | | |  | | | | | | | | |  |
| Mental Health & Justice Support Coordination is a Voluntary Service. Please ensure the person you are referring consents to this referral. **Incomplete referrals will not be processed and will be returned.** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **1. Client Information** | | | | | | | | | | | | | | | | |
| Legal Name: | | | | | | | Preferred Name: | | | | | | | | | |
| Date of Birth: | | | | | | | Age: | | | | | | | | | |
| Health Card Number: | | | | | | | Version Code: | | | | | | Expiry Date: | | | |
| Preferred Pronouns: | | | | | | | | | | | | | | | | |
| Identifies as a Member of the BIPOC (Black, Indigenous, People of Colour) Community? | | | | | | | Yes  No | | | | | | | | | |
| Identifies as a Member of the 2SLGBTQ+ Community? | | | | | | | Yes  No | | | | | | | | | |
| Address: | | | | | | | City: | | | | | | | | | |
| Postal Code: | | | | | | | Phone Number: | | | | | | | | | |
| Can confidential messages be left at this number? | | | | | | | Yes  No | | | | | | | | | |
| If no phone, what is the best way to reach the client? | | | | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | | | | |
| **Alternate Contact Information:** | | | | | | | | | | | | | | | | |
| Name: | | | | | | | Phone Number: | | | | | | | | | |
| **Emergency Contact Information:** | | | | | | | | | | | | | | | | |
| Name: | | | | | | | Phone Number: | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | |
| **2. Referral Information:** | | | | | | |  | | | | | | | | | |
| Is this an existing client of CMHA WW? | | | | | | | Yes  No | | | | | | | | | |
| Referrer Name: | | | | | | | Referral Date: | | | | | | | | | |
| Referral Organization: | | | | | | | Phone Number: | | | | | | | | | |
| Is the client aware of the referral? | | | | | | | Yes  No | | | | | | | | | |
| How did the mental health issue(s) contribute to the charges?: | | | | | | | | | | | | | | | | |
| Reason for referral: (e.g., presenting issues, support goals, current symptoms): | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **3. Current Legal Situation:** | | | | | | | | | | | | | | | | |
| Custody Status: | In Custody | | | | Out of Custody | | | | | On Probation | | | | | When is probation completed? | |
|  |  | | | |  | | | |  | | | |  | | | |
|  |  | | | |  | | | |  | | | |  | | | |
| Does the client have outstanding criminal charges? | | | | | | | | Yes | | | No | | | | | |
| If yes, what are the charges? | | | | | | | | | | | | | | | | |
| Does the client have a lawyer? | | | | | | | | Yes | | | No | | | | | |
| If yes, please state who it is: | | | | | | | | | | | | | | | | |
| Has the client requested/received disclosure? | | | | | | | | Yes | | | No | | | Not Applicable | | |
|  | | | | | |  | | | | | | | | | | |
| **4. Diagnoses/Medical Information:** | | | | | |  | | | | | | | | | | |
| Current primary Diagnosis and Other Diagnoses: | | | | | | | | | | | | | | | | |
| Please describe hospitalizations and emergency department visits within the last year: | | | | | | | | | | | | | | | | |
| Current Medications: | | | | | | | | | | | | | | | | |
| Pharmacy (please include contact information): | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **5. Substance Use/Addictions:** | | | | | | | | | | | | | | | | |
| Substance Use (e.g., current substance, amount, frequency): | | | | | | | | | | | | | | | | |
| Other Addiction Issues (e.g., gambling, video gaming, etc.): | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **6. Risk Concerns:** | | | | | | | | | | | | | | | | |
| Risk Concerns (e.g., suicidal ideations, harm or neglect to self, threat to others, violent behavior, fire setting, access to weapons): | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **7. Potential Barriers:** | | | | | | | | | | | | | | | | |
| Potential Barriers to Engagement/Service (e.g., insight, transient, medical complexities, literacy, language): | | | | | | | | | | | | | | | | |
| **8. Community Supports:** | | | | | | | | | | | | | | | | |
| List Existing Community Supports and Contact Information: (e.g., Physician, Nurse Practitioner, Psychiatrist, Probation Officer, Bail Supervisor): | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | |
| **9. Available Supporting Documentation**: | | | | | | | | | | | | | | | | |
| Discharge Summaries | | | | Medication Record | | | | | | | | Consents | | | | |
| Legal Information | | | | Other Relevant Consults | | | | | | | |  | | | | |
|  | | | |  | | | | | | | |  | | | | |
| **10. Next Criminal Court Appearance:** | | | | | | | | | | | | | | | | |
| Date: | | | | | | | Time: | | | | | | | | | |
| Courtroom: | | | | | | | Location: | | | | | | | | | |
| Previous Legal Involvement (e.g., past convictions, forensic system, Family Court matters, diversions): | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **If you have any questions about the referral process, please call Here 24/7 for assistance,**  **1-844-437-3247. Please fax completed referral to Here 24/7 at – 1-844-437-3329.** | | | | | | | | | | | | | | | | |
| Completed By: | | | | | | | Position: | | | | | | | | | |
| Date: | | | | | | | | | | | | | | | | |