| **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):  |
|  |
|  |
|  |
| **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:  |