

Mental Health and Justice Prevention Program

REFERRAL FORM

Client Information

| | | | |
|----------------------------|------------------------|-------------------------|--------------|
| First Name: | | Last Name: | |
| Age: | Date of Birth (D/M/Y): | Gender: | |
| Languages Spoken: | | Income Source: | |
| Contact Information | Street Address: | | Apt. # |
| | City: | | Postal Code: |
| | Telephone: | Other Means of Contact: | |

Health Card Number : _____ **Version Code:** _____

Mental Health Issues/Diagnosis:

Medical Problems of Concern:

Current/Past Criminal Charges: YES NO If yes, please list:

Current Supports (please complete the following):

| Y/N | Relationship | Name | Telephone Number |
|-----|--------------------------|------|------------------|
| | Family | | |
| | Peers/Friends | | |
| | G.P. | | |
| | Psychiatrist | | |
| | Therapist | | |
| | Case Manager | | |
| | Probation/Parole Officer | | |
| | Lawyer | | |
| | Court Support | | |
| | Other | | |
| | | | |
| | | | |
| | | | |

| Eligibility Criteria | | | |
|--|---|---------------------------------------|-----------------------------|
| PLEASE CHECK ALL THAT APPLY | | | |
| Must meet all <u>THREE</u> of these criteria | Individual is 16 years or older and has serious mental health issue (concurrent/dual diagnosis or cognitive disability included) | | |
| | Individual can benefit from a community mental health service | | |
| | Likely to be safely supported in the community | | |
| Also must meet <u>ONE</u> of these criteria | Police, probation or parole referral (including moderate to high risk of being charged) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Current charges, past charges, or release from custody in the past year | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>If one of the above criteria re: justice involvement cannot be met, the following should be used to determine eligibility</i> | | | |
| Must have <u>FIVE</u> or more of these risk factors | Two or more prior convictions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Current substance abuse of significant history of substance abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Poor living arrangement, i.e. homeless, at risk of homelessness, or three or more address changes in the past year | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Current family conflict | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Financial stress, i.e. applicant's financial situation is a current stressor | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Lacks informal social supports | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Subject of two or more police mental health calls or apprehensions within the past year | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | History of violence | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Active symptoms of a major mental illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Absence of participation in an organized activity, i.e. employment, school, volunteer work, leisure activity, mental health or social support programming | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Referral Source Information | | | |
| Name of Person Completing this Form: | | | |
| Telephone: | Ext.: | Fax: | Email |
| Name of Organization/Program: | | | |
| Reason for referral: | | | |
| | | | |
| Client is aware of this referral? YES <input type="checkbox"/> NO <input type="checkbox"/> | | Date this form was completed (D/M/Y): | |
| Are there any safety risks staff should be aware of in delivering services? | | | |

STEELES AVE

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|------------------------|--|---|---|-------------------|
| ETOBICOKE CREEK | Reconnect 1281 St Clair Ave W Toronto, ON M6E 1B8 Ph: 416-248-2050 Fax: 416-248-6557 www.reconnect.on.ca | COTA 700 Lawrence Ave West Suite 325 Toronto, ON M6A 3B4 Ph: 416-785-9230 Fax: 416-785-9358 www.cotainspires.ca | CMHA Toronto 1200 Markham Road, Suite 500 Toronto ON M1H 3C3 Phone: 416-789-7957 ext. 6285 Fax: 416-289-6843 Intake: 416-458-9466 www.toronto.cmha.ca | PORT UNION |
| | KEELE ST | EGLINTON AVE | VICTORIA PARK AVE | |
| |  | Sound Times 280 Parliament Street Toronto, ON M5A 3A4 Ph: 416-979-1700 Fax: 416-979-8354 www.soundtimes.com |  | |

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