NORTH YORK GENERAL

Mental Health and Justice Treatment and Support Services

REFERRAL FORM

1. IDENTIFICATION OF CLIENT

Last Name: **First Name:** **Gender:**

Address:

City: **Province:**

Postal Code:

Telephone: **DOB:**

Health Card #: **(MM/DD/YY)**

Has this patient previously been treated at North York General Hospital? ❑ Yes ❑ No

If you are a physician and the referring source please state Provider Number:

Please attach any information which will assist in the assessment and treatment of the patient, such as admission notes, discharge summary, police synopsis:

Marital Status:

❑ Single ❑

❑ Couple/partner ❑

Citizenship: ❑ Canadian ❑ Landed Immigrant

Languages spoken: **Languages written:**

Next of kin:	**Relationship:**
Address:	
City:	**Province:**
Postal Code:	
Telephone:	

Emergency contact:	**Telephone:**

Source of Income:

2. REASONS FOR REFERRAL

Court/Criminal Charge that led to referral:

Present legal status of client:	❑ In Custody:	❑ On Bail:	❑ On Probation:	❑ WF Trial:

Type of service needed and time frame:

3. BRIEF LEGAL HISTORY

Is this a first offence? If not, briefly describe past offence(s):

Is the person currently on probation/parole? If yes, what is the Probation Officer's name?

Telephone:

Does the person have any of the following?

Power of Attorney for personal care	❑	Power of Attorney for Property	❑	Public Guardian and Trustee	❑	Other(s)	❑

If other, please specify:

4. BRIEF MENTAL HEALTH HISTORY

Has the person ever been hospitalized for mental health reasons? Yes / No

Health problems:

Name of current physician: **Telephone:**

Name of current psychiatrist **Telephone:**

Primary diagnosis: **Secondary diagnosis:**

Does the person have a substance abuse problem? If yes, was the substance abuse problem related to the offence?

5. SAFETY ISSUES

Does the person have a history of making violent threats/gestures?

Does the person have a history of making self-harming threats/gestures?

6. REFFERAL SOURCE

Name: **Position:**

Place of Work: **Telephone:**

Person making the referral if different from above:

Name: **Telephone:**

If he/she was admitted to our program, would you be involved in the person's treatment and/or follow-up? Yes / No

If yes, please specify:

Signature: **Date**:

Please forward the form to:

MHJTSS (Mental Health and Justice Treatment and Support Services)
North York General, Branson Ambulatory Care Centre
555 Finch Avenue West
Toronto, ON M2R 1N5
Tel: 416.632.8701
Fax: 416.632.8718