

**Mental Health & Justice  
 Treatment & Support Services  
 REFERRAL FORM**

FORM SF0146

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Patient LABEL / Identification Area

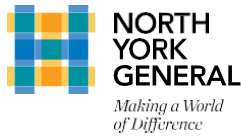
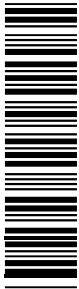
Patient Name: \_\_\_\_\_

<b>Eligibility Criteria:</b> All referrals <u>must</u> be made from a source connected directly to the criminal justice system (i.e. lawyers including duty counsel, probation, parole, court program, bail program). If the request for service is not being requested directly from the criminal justice system, we will not accept the referral regardless of criminal justice involvement. Please have the individual be referred directly from a referring source attached to the criminal justice system.	
We provide services to individuals living in North York. We will accept referrals for individuals living in other areas of the GTA; however, we encourage referring sources to look at services available to the patient in their own community prior to referring (this is in the best interest of the individual and will also limit our wait times for service). We will not accept referrals for individuals living outside of the GTA.	
<b>The individual must meet <u>ALL</u> of these criteria</b>	Is between the ages of 18-65 years.
	Has an ongoing mental health concern.
	Has <b>ACTIVE</b> involvement in the <u>criminal justice system</u> (i.e. criminal charges before the courts, probation, parole).
	Can be treated safely in an outpatient mental health setting.
	Is willing to engage in ongoing mental health treatment.
	Has a <b>VALID</b> OHIP card.
<b>Ineligibility Criteria: Unfortunately we <u>cannot</u> provide treatment for the following conditions and charges.</b>	Individuals living with a dual diagnosis (development delay and mental health concern).
	We will not provide services to individuals who have a diagnosis of ADHD/ADD or suspected ADHD/ADD without any other mental health concerns.
	Substance use disorder without a mental health concern.
<b>This program does not provide the following services</b>	Risk assessments, Housing support or case management
	Psychological testing or reports (we have psychiatrists on staff not psychologists), Couples or family counselling.
	Counselling for trauma related to sexual abuse
	Psychiatry services to individuals who already have a psychiatrist in the community

**Please contact us prior to making a referral for the circumstances listed below. We will assess these referrals on a case-by-case basis only.**

- Charges and/or convictions for: murder, manslaughter, infanticide, arson, any charges directly related to the abuse of children, firearm charges, sexual offences (including sexual assault, sexual interference, child pornography, voyeurism etc).
- Charges and/or convictions of theft under \$5000, fraud charges, and minor mischief charges will be considered on a case-by-case basis when the diagnosis (or suspected diagnosis) is ADHD, depression, anxiety. We will not accept referrals in cases where there is not a strong link between the individual's mental health and offending behaviour. If accepted, these individuals will be provided with counselling services only and will not be eligible for psychiatry services in our program.

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



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Please forward the referrals form to:

**MHJTSS (Mental Health and Justice Treatment and Support Services)  
North York General Hospital  
Tel: 416-756-6919 Fax: 416-756-6318**

Has the patient previously been treated at North York General Hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

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

**If you are unsure as to whether a referral is appropriate, please contact us directly to discuss the referral.**

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_

Health Card#: \_\_\_\_\_

(Include version code & expiry date) (\*please attach a photocopy of card if available)

Patient DOB: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

- Citizenship:**
- Canadian
  - Permanent Resident
  - Landed Immigrant
  - Refugee Status
  - Other

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Next of kin:** \_\_\_\_\_ **Telephone:** (      )

**Address:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Province:** \_\_\_\_\_

**Postal Code:** \_\_\_\_\_

**Telephone:** (      )

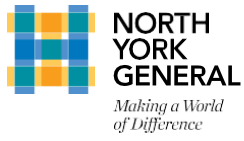
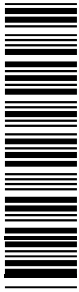
**Does the patient have any of the following?**

**Languages spoken:** \_\_\_\_\_ **Languages written:** \_\_\_\_\_

**Source of** \_\_\_\_\_

**income:** \_\_\_\_\_

- Power of Attorney for personal care
- Power of Attorney for Property
- Public Guardian and Trustee



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Other(s)



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If other, please specify:  
**REASON FOR REFERRAL**

Present legal status of patient (please check all that apply):	<input type="checkbox"/> In Custody	<input type="checkbox"/> On Bail	<input type="checkbox"/> On Probation/Parole (expiry date)	<input type="checkbox"/> Mental Health Diversion	<input type="checkbox"/> Awaiting Trial	<input type="checkbox"/> Awaiting Sentencing

Charge(s)/Conviction(s) that led to referral:

Please provide any documentation that would assist us in providing treatment such as: police synopsis, bail conditions. If the patient has active charges before the court and a report is being requested a police synopsis (or a discussion with the court worker or lawyer if synopsis is unavailable) and any bail conditions are required.

Type of service needed and time frame:

- Mental health assessment
- Psychiatric assessment
- Anger management
- Mental health counseling (Please be specific. Identify areas of concern)
- Letter/Report for court
- Other:

**LEGAL HISTORY**

Is this a first offence?

- Yes
- No, please briefly describe past offence(s):

If the patient is currently on probation/parole please list the Probation Officer's name and contact information

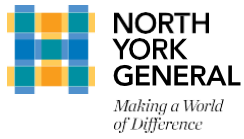
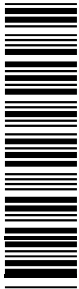
Name: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

Probation Office: \_\_\_\_\_

**BRIEF MENTAL HEALTH HISTORY:**

Has this patient ever been hospitalized for mental health reasons?  Yes  No  
 Primary diagnosis: \_\_\_\_\_ Secondary diagnosis: \_\_\_\_\_

**Physical Health Concerns:** \_\_\_\_\_



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**Name of Family Physician:**



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**Name of Current  
Psychiatrist**

**Does this patient have a substance abuse problem?**

- Yes**
  - Please briefly describe (i.e. substances used)**
  
  - Was substance abuse related to the offence? (Specify)**
  
- No**

**SAFETY CONCERNS**

**Does the patient have a history of making violent threats or gestures?**

**Does the patient have a history of making self-harming threats or gestures?**

**If the patient was admitted to our program, would you be involved in the patient's treatment and/or follow-up?**

- No**
- Yes, please specify:**

**REFERRAL SOURCE:**

**Name:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Place of Employment:** \_\_\_\_\_

**Telephone:** (      ) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_