NORTH YORK GENERAL
Making a World of Difference

Mental Health & Justice Treatment & Support Services REFERRAL FORM

Patient LABEL / Identification Area

Patient Name: _____

Eligibility Criteria: All referrals must 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.

The individual must meet ALL of these criteria	Is between the ages of 18-65 years.
	Has an ongoing mental health concern.
	Has **ACTIVE** involvement in the criminal justice system (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 **VALID** OHIP card.
Ineligibility Criteria: Unfortunately we cannot provide treatment for the following conditions and charges.	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.
This program does not provide the following services	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:** **Telephone:** ( )
Next of kin:	**Relationship:**
Address:	
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):	❑ In Custody	❑ On Bail	❑ On Probation/Parole (expiry date)	❑ Mental Health Diversion	❑ Awaiting Trial	❑ 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:**_____