

**Mental Health and Justice Initiative Crisis Prevention Program**

**REFERRAL FORM**

**Client Information**

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

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

<b>Must meet all <u>THREE</u> of these criteria</b>	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		
<b>Also must meet <u>ONE</u> of these criteria</b>	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

*If one of the above criteria re: justice involvement cannot be met, the following should be used to determine eligibility*

<b>Must have <u>FIVE</u> or more of these risk factors</b>	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
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Name of Organization/Program:

Reason for referral:

Client is aware of this referral?  
YES  NO

Date this form was completed (D/M/Y):

Are there any safety risks staff should be aware of in delivering services?

## Steeles Ave

<b>Etobicoke Creek</b>	<b>RECONNECT</b> 2150 Islington Avenue, Suite 202 Etobicoke, ON M9P 3V4 Ph: 416-248-2050 Fax: 416-248-6557 www.reconnect.on.ca	<b>COTA</b> 1110 Finch Ave West Suite 700 Toronto ON M3J 2T2 Ph: 416-514-1425 Fax: 416-514-1430 www.cotahealth.ca	<b>COTA Health</b> <i>Choose Experience. Expect Results.</i>	<b>CMHA</b> Canadian Mental Health Association, Toronto Branch 1200 Markham Road, Suite 500, Toronto ON M1H 3C3 Ph: 416-289-6285 Fax: 416-289-6843 Intake: 416-458-9466 www.toronto.cmha.ca	<b>Port Union</b>
		<b>Eglinton Ave</b>	<b>SOUND TIMES</b> 280 Parliament street Toronto ON M5A 3A4 Ph: 416-979-1700 Fax: 416-979-8354 www.soundtimes.com		
<b>Lake</b>					


**CANADIAN MENTAL HEALTH ASSOCIATION**  
 L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE  
 Toronto Branch