YOUTH SERVICES JEUNESSE

Client Name: _____

Date of Birth: _____

Youth Mental Health Court Referral Form

Case #: 2_-Y _____ Next Court Date: _____ Referral Source: -- _____
i.e. 23-Y1109222

Reason for referral request: (please select from drop down menu and provide detail below) -- _____

Counsel: (Duty or Defence) _____

_____ _____

Phone number E-mail Address

Date of Referral Request: _____

WE REQUEST: Client to call YMHCW within 7 days of referral being accepted to express interest in program: Michelle 613-808-0524. To note: Client must waive 11 (b) for the duration of the program. This is mandatory. Please check this box to confirm that client has provided consent to be discussed at Counsel Pre-Trial ☐

Client Information:

Client Phone Number: _____

Legal Guardian: _____

Phone Number: _____

Name of psychiatrist (if applicable):

_____

Professional community Mental Health Involvement:

- ☐ Social Worker (CAS or other)
- ☐ ISSP Worker
- ☐ CST Worker
- ☐ Others: _____

**Alternatively, you may include a separate sheet with list of relevant professionals*

Mental Health Diagnosis:

- ☐ Major mood disorders (depression, Bipolar disorder)
- ☐ Anxiety disorder
- ☐ Developmental disorders
- ☐ Schizophrenia
- ☐ Other psychotic disorders
- ☐ Substance use disorders and substance-induced
- ☐ PTSD
- ☐ Disruptive behavioural disorder
- ☐ Others: _____