CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Halton Region Branch

COMMUNITY TREATMENT COURT REFERRAL FORM

(Please Print)

Today's date:	

CLIENT INFORMATION

Client's last name:	First:	Middle:	Birth date: / /	Age:	Sex: ❑ M ❑ F ❑ Other

Email:	Home phone no:	Cell phone no:	Postal Code:

Street address:	City:	Province:

REFERRAL SOURCE

Name of Referral Source	Relationship to Client:	Phone No.: ( )	Fax No.: ( )

CRIMINAL JUSTICE INVOLVEMENT

Next Court Appearance(s):	Courtroom Number:	Custody (check one) ❑ In ❑ Out	

Charges/Prior Criminal Record:

MENTAL HEALTH

Mental Health Concerns:

Diagnosis:

Medication:

Hospitalizations:
Name: Date:
Name: Date:
Name: Date:

Psychiatrist:	Involved Since:	Phone No.: ( )	Fax No.: ( )
General Physician:	Involved Since:	Phone No.: ( )	Fax No.: ( )
Community Supports:	Involved Since:	Phone No.: ( )	Fax No.: ( )
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OTHER FACTORS	
Substance Use Concerns:	Safety Concerns:
Source of Income:	Disabilities (Physical, Developmental, FASD, ABI):

OTHER RELEVANT INFORMATION

INTERNAL USE ONLY
Date referral received :
Date client contacted: