



**Justice Support Service Referral Form**

Court Support       Release From Custody

Is the individual aware that a referral is being made on their behalf?       Yes       No

**Section A: Personal Information**

Legal Client Name:		Pronoun:	
Preferred Name:			
Date of Birth (DD/MM/YY):		Age:	
Address:		Phone #:	
City:		Postal Code:	
Health Card #:		Version Code:	
Emergency Contact Name:			
Address:			
Phone #:		<input type="checkbox"/>	Okay to leave message

**Section B: Referral Source Information**

Referral Date (DD/MM/YY):			
Source Type	<input type="checkbox"/> Correctional Facility	Name of Agency/Facility	
	<input type="checkbox"/> Probation and Parole Office		
Legal Advisor:			
Person Referring Client			
Relationship:			
Reason for Referral:			
Mental Health Diagnosis:			
Medications:			
Describe Mental Health and/or Physical Health Concerns:			

Identify areas of risk/concern relevant to this individual or environment:
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**Fax completed form to Windsor Essex CMHA: 519-971-0058**  
 CMHA Team Member will respond as soon as possible to begin assessment for service.

**C: Criminal History**

Current Charges:	
Historical Charges:	
Next Court Date:	
Release Date:	

**Section D: Consents**

<b>Consents Obtained (If staying at a shelter, consent for messages is very helpful):</b>			
For:		Date (DD/MM/YY):	
For:		Date (DD/MM/YY):	
For:		Date (DD/MM/YY):	

**Section E: Additional Information** (ie. community services, accessibility, language, etc.)

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**Client Consent for Referral to CMHA-WECB:**

I, \_\_\_\_\_ Consent to be assessed by the Canadian Mental Health Association, Windsor-Essex County Branch, Release from Custody/Court Support staff. I understand that the CMHA staff may be obtaining and exchanging information concerning me with other sources to assist in the completion of the assessment. I hereby consent to any disclosure, transmittal, examination or exchange of such information between these interested parties. I understand and consent that anything I say and any information obtained in the course of preparation of the assessment may be shared with the Crown and defense attorney/duty counsel.

**SWDC MAY RELEASE MEDICAL/MENTAL HEALTH INFORMATION TO CMHA:**

Initials: \_\_\_\_\_

Client Signature: _____	Date: _____
Worker Signature: _____	Date: _____

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