YOUTH SERVICES JEUNESSE

Client Name: _____

Date of Birth: _____

Youth Mental Health Court Referral Form

Scope ID: _____ Next Court Date: _____ Referral Source: -- _____

Reason for referral request:

Defence Counsel: _____

_____ _____

Phone number E-mail Address

Date of Referral Request: _____

WE REQUEST: Client to call YMHCW within 7 days of referral 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.

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: _____