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**YOUTH MENTAL HEALTH COURT REFERRAL FORM**

**Client Name:** **(please print)**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 DD/MM/YEAR**

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Charges: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next court date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral request:

Defence Counsel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information of counsel: Click or tap here to enter text. Click or tap here to enter text.  
 Phone number E-mail Address

Date of referral request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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 disorders

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT INFORMATION:**

Legal Guardian: Click or tap here to enter text. Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of psychiatrist (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Community Mental Health professional involvement:

Social Worker (CAS or other)

ISSP Worker

CST Worker

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_