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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_