Justice and Public Safety
Community and Correctional Services, Clinical Services
PO Box 2000, 14 MacAleer Drive
Charlottetown
Prince Edward Island
Canada C1A7N8

CLINICAL SERVICES REFERRAL FORM

(Complete ALL Relevant Sections)

CLIENT NAME: _____

DATE OF BIRTH **(M/D/Y):** _____AGE: _____ GENDER (optional): _____

PARENTS NAME (IF YOUTH):_____

MAILING ADDRESS: _____

EMAIL ADDRESS (if applicable):_____

TELEPHONE: (h) _____(c) _____

NUMBER OF CHILDREN IN THE HOME: _____

REFERRED BY:_____ PHONE #:_____

EMAIL: _____

AGENCY:_____DATE REFERRED: _____

o YOUTH	o COMMUNITY
o ADULT	o CUSTODY: PRCC____ PCC____ PEIYC_____

PROGRAM/SERVICE REQUESTING:

o Turning Point	o Youth Mental Health Counselling
o Sexual Offence	o Youth Related Family Counselling
o Emotion Regulation (Anger Management)	o Indigenous Case Worker

Presenting Issues: _____

_____

_____

Suicide Risk*:*

THOUGHTS/IDEATION_____

PREVIOUS ATTEMPTS_____

FAMILY HISTORY_____

PLAN _____

LEGAL INFORMATION

COMPLETE ALL:

Legal Status	Commenced	Expires
(____) Probation order	_____	_____
(____) Alternative Measures	_____	_____
(____) Custody	_____	_____

(____) Awaiting court appearance Date: _____

CHARGES/CONVICTIONS: _____

Does client consent to release information? _____ YES_____ NO

Have you discussed?

Referral ____ YES _____NO

Assessment ____ YES _____NO

Group Programming ____ YES _____NO

List ALL Previous Offences: (Include additional pages if necessary**)**

Date Charged/Convicted	**Description of Offence(s)**

Current Agency Involvement	**Nature of Service**	**Dates**	**Contact**

MENTAL HEALTH

PRESENTING SYMPTOMS WITHIN THE PAST FOUR WEEKS: (Check all that apply)

o Extreme fatigue	o Easily irritated
o Experiencing flashbacks/nightmares	o Severe restlessness
o Sleep disruption	o Social withdrawal
o Extreme high or low moods or both	o Excessive fear or worry
o Appetite disturbance	o Poor concentration
o Abnormal thought content/processing	o Describes hearing voices
o Self-harming behavior	o Substance abuse issue

Please describe above or other symptoms in detail:

TURNING POINT REFERRAL (Complete if applicable**)**

Victim's name: _____

Current relationship status: _____

Address: _____

Telephone: _____

Victim Service Worker (if known): _____

SEXUAL OFFENCE ASSESSMENT/TREATMENT PROGRAM
(Complete if applicable)

NATURE OF SEXUAL OFFENCE BEHAVIOR: (e.g. child molestation, rape, voyeurism, exhibitionism, etc.):

POSSIBLE CONTRIBUTING FACTORS: (e.g. drug use, impulsivity, family dynamics)

PREVIOUSLY ATTENDED ASSESSMENT/TREATMENT? ____ YES _____ NO

INDIGENOUS CASE WORKER REFERRAL
(Complete if applicable)

Gladue/Sentencing circle recommendations:

Alternative measures/probation order recommendations:

Additional Information:

Level of Service (Please check):

(ADULT) LS/CMI _____ SCORE_____ (YOUTH) YLS/CMI 2.0 ____ SCORE_____

RISK/NEED LEVEL_____ DATE OF ASSESSMENT_____

INFORMATION/REPORTS ENCLOSED WITH THE REFERRAL

(Please include all applicable documents and check if not available):

Documents	Available	Not available	Unknown	Documents	Available	Not available	Unknown
Pre-sentence Report				**Victim's Police Statement**			
Probation Orders				**LS/CMI or YLS/CMI 2.0**			
Alternative Measures Agreement				**Psychological Assessment**			
Agreed Statement of Facts/Crown Brief				**Psychiatric Assessment**			
Police Report				**Gladue Report**			
Offender's Police Statement				**Sentencing Circle Recommendations**			
Report of investigating officer				**Release of Information**			
Victim Impact Statement				**Please call for additional information (check one)**	**YES**	**NOT Required**	**Unknown**

Additional information/identify barriers to client attendance:

Will a translator be required? If so, for what language?

Personal information is collected under section 116 of the Youth Criminal Justice Act or the Correctional Services Act and/or section 31© of the Freedom of Information and Protection of Privacy Act. It will be used for providing service to a client of Community and Correctional Services.

Please forward referrals to:

Clinical Services
PO Box 2000
14 MacAleer Drive,
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C1A7N8

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