



Justice and Public Safety
 Community and Correctional Services
 Clinical Services
 PO Box 2000
 14 MacAleer Drive Charlottetown
 Prince Edward Island
 Canada C1A 7N8



Justice et Sécurité publique
 Services communautaires et
 Services cliniques
 PO Box 2000
 14 promenade MacAleer
 Charlottetown
 Ile-du-Prince-Edouard
 Canada, C1A 7N8

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: _____

<input type="radio"/> YOUTH <input type="radio"/> ADULT	<input type="radio"/> COMMUNITY <input type="radio"/> CUSTODY: PRCC___ PCC___ PEIYC___
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PROGRAM/SERVICE REQUESTING:

<input type="radio"/> Turning Point	<input type="radio"/> Youth Mental Health Counselling
<input type="radio"/> Anger Management (Emotion Regulation)	<input type="radio"/> Youth Related Family Counselling
<input type="radio"/> Sexual Offence	<input type="radio"/> 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)

<input type="checkbox"/> Extreme fatigue	<input type="checkbox"/> Easily irritated
<input type="checkbox"/> Experiencing flashbacks/nightmares	<input type="checkbox"/> Severe restlessness
<input type="checkbox"/> Sleep disruption	<input type="checkbox"/> Social withdrawal
<input type="checkbox"/> Extreme high or low moods or both	<input type="checkbox"/> Excessive fear or worry
<input type="checkbox"/> Appetite disturbance	<input type="checkbox"/> Poor concentration
<input type="checkbox"/> Abnormal thought content/processing	<input type="checkbox"/> Describes hearing voices
<input type="checkbox"/> Self-harming behavior	<input type="checkbox"/> 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):

<u>Documents</u>	Available	Not available	Unknown	<u>Documents</u>	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
Charlottetown, PE
C1A7N8**

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