Prince Edward Island
CANADA

Justice and Public Safety
Community and Correctional Services
Clinical Services
124 Deacon Grove Lane
Charlottetown
Prince Edward Island
Canada C1A 7N5

CLINICAL SERVICES REFERRAL FORM

(Complete ALL Relevant Sections)

CLIENT NAME: ____

DATE OF BIRTH (**M/D/Y**): _______________AGE: _____ GENDER: _____________________

PARENTS NAME (IF YOUTH):____

MAILING ADDRESS: ____

EMAIL ADDRESS (if applicable):____

TELEPHONE: (h) ______________________(c) _______________________________________

NUMBER OF CHILDREN LIVING IN HOME: ______

REFERRED BY:_____________________________ PHONE #:_________________________

EMAIL: ____

AGAINST:

AGENCY:___________________________DATE REFERRED: _________________________

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

PROGRAM/SERVICE REQUESTING:

o Adult Mental Health Counselling	o Turning Point
o Youth Mental Health Counselling	o Sexual Deviance
o Youth Related Family Counselling	o Indigenous Case Worker
o Anger Management	

Presenting Issues:

Suicide Risk:

THOUGHTS/IDEATION____

PREVIOUS ATTEMPTS____

FAMILY HISTORY____

PLAN ____

LEGAL INFORMATION

COMPLETE ALL:

Legal Status | Commenced | Expires

(____) Probation order ________________ ____________________

(____) 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: (Complete if applicable)

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 DEVIANCE ASSESSMENT/TREATMENT PROGRAM
(Complete if applicable)

NATURE OF DEVIANT SEXUAL 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:

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
124 Deacon Grove Lane,
Charlottetown, PE
C1A7N5

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