St. Leonard's
COMMUNITY SERVICES
Challenge. Choices. Change.

ST. LEONARD'S COMMUNITY SERVICES
MENTAL HEALTH AND CONCURRENT DISORDERS CASE MANAGEMENT

Brantford Jail Referral Form

Referral Date: _____

Client Name: _____

Client DOB: _____

Address: _____
_____
_____

Phone Number: _____

Name of Person Referring: _____

Telephone Number: _____

Please check the appropriate program:

☐ **Mental Health Case Management (Please fax referral and consent to release information to (519) 756-4329)**

☐ **Concurrent Disorders Case Management (Please fax referral and consent to release information to (519) 756-4329)**

Please provide the following information:

1. **Reason for incarceration:**

2. **Referral source assessment of alcohol/drug/gambling issues and/or mental health concerns and any additional information pertinent to your assessment.**

3. **Client's view of the problem.**

4. **Mental Health Issue/Diagnosis (i.e. Schizophrenia, Bi-polar, Major Depression):**

5. **Current Medications:**

6. **Was the client receiving psychiatric services prior to incarceration?**

   ☐ **Yes Name of Psychiatrist:**

   ☐ **No**

7. **Does the client require housing upon release?**

   ☐ **Yes**

   ☐ **No**

8. **Does the client have identification i.e. birth certificate, health card, etc?**

   ☐ **Yes**

   ☐ **No**