BC MENTAL HEALTH
& SUBSTANCE USE SERVICES
Provincial Health Services Authority

Forensic Liaison Referral Form

Referral to:	PLEASE SPECIFY

Client Name (and alias):		**Date of *Birth*** *(yy/mm/dd)*:	
Court Location:		**Location of Client:**	

Date of Arrest:		**Next Court Appearance:**	
Court File No.:		**RCMP FPS#:**	

Referral for: ☐ Mental Status Exam ☐ Community Services ☐ Query Fitness

Please add details of referral:

Crown Counsel							
Name:		**Office:**		**Phone:**		**Email:**	
Comments:							

Defence/Duty Counsel
IF DEFENCE/DUTY COUNSEL OPPOSED – REFERRAL CANNOT PROCEED

Name:		**Phone:**		**Email:**	
Position on Referral: ☐ **Consent** ☐ **Not Opposed** ☐ **No Instructions**					
Able to Interview Accused? ☐ **Yes** ☐ **No**					
Comments:					

Current Charges

Charge(s)	Date (yy/mm/dd)	Stage of Court Proceedings	C.C.C. Section

Forensic Psychiatric Services – to complete below:

Forensic MRN #: **Personal Health #:**	**Forensic Liaison Name:** **Forensic Psychiatrist Consult** ☐ **Y** ☐ **N** **Dr:**	**Community Health Services:**	**Client Family Contact Info:**
Recommended Action: **Unable to conduct interview due to:** ☐ Virtual Equipment Access ☐ Client Refused Interview			