

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: <input type="checkbox"/> Mental Status Exam <input type="checkbox"/> Community Services <input type="checkbox"/> 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: <input type="checkbox"/> Consent <input type="checkbox"/> Not Opposed <input type="checkbox"/> No Instructions			
Able to Interview Accused? <input type="checkbox"/> Yes <input type="checkbox"/> 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 #:	Forensic Liaison Name:	Community Health Services:	Client Family Contact Info:
Personal Health #:	Forensic Psychiatrist Consult <input type="checkbox"/> Y <input type="checkbox"/> N Dr:		
Recommended Action:			
Unable to conduct interview due to: <input type="checkbox"/> Virtual Equipment Access <input type="checkbox"/> Client Refused Interview			