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			