

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